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ABSTRACT

A broad range of issues which concern professional counselors is covered in these two journal issues. The articles include: New York State Counselor Licensure: An Overview (Terry Bordan and Judith Ritterman); The Research and Publishing Process: A Rational Approach (A. Scott McGowan); The Student-Athlete Dichotomy: Helping Students Fulfill Their Dual Roles (Frank Brady); Adolescent Egocentrism and Its Relationship to HIV and AIDS (Kevin A. Curtin); Social Constructionist Counseling with Families When a Child has Been Raped (June A. Smith and Alanzo H. Smith); Childhood Chronic Illness and Families: A Review of the Literature and Implications for Counselors (Phillis A. Gordon, et al.); Culture and Empowerment: Counseling Services for Immigrant Chinese American Families (George K. Hong); Influences on the Philosophy and Practice of a School Counselor: A Personal Perspective (George F. DeHaas); Effective Changes in Admissions Requirements and Procedures in a CACREP Accredited Masters Program (Basilia C. Softas Nall and Tracey D. Bostwick Baldo); Establishing a Successful Private Practice: Some Practical Considerations (Terry Bordan and Marjorie S. Demshock); Bystanders: An Overlooked Factor in Peer on Peer Abuse (Richard J. Hazler); The Relationship between Esophageal Speech Acquisition and Self-Concept Following Total Laryngectomy (Dianne C. Slavin and Joyce A. Rubenstein); Children from Chemically Dependent Families: An Evaluative Study (Dawn Pieper and Jill Carlson Zimmerman); Fairy Tales and Symbols: Gaining Access to the Unconscious (Camille C. Copeland, et al.); New Approach to Counseling (Phyllis Rubenfeld); Managed Care and Health Care Reform: Implications for Professional Training and Practice (Tony D. Crespi and Mary E. Steir); Counseling Clients with HIV and AIDS: A Review of Ethical and Legal Issues (Burnice L. Hayes); and Collaborative Interventions for Children with Chronic Behavior Problems (Diane Dempsey Marr). (RJM)

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The Journal for the Professional Counselor

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Message from the President

Dante J. Ascenzi

As members of a most dynamic profession, we have an obligation to stay abreast of current issues in counseling. We need counselors who meet and practice their skills at the highest level possible in order to serve a varied and diverse population. The *New York Counseling Association* is committed to providing its members with pertinent, timely and quality information. Association members are very fortunate indeed to have access to perhaps the most comprehensive, practical and theoretical collection of scholarly work in the business, *The Journal for the Professional Counselor.*

As we move closer toward the next century, we can be proud of the way that NYCA has advocated for the counseling profession with our commitment to licensure, promoting prevention programs, increasing the scope of counselor specialities, and working for social justice among other agendas. The beacon which helps guide the direction of NYCA is *The Journal.* It is not by accident that this publication serves as the counseling standard for the rest of the country. The current editor, Dr. Terry Bordan, and her predecessor, Dr. A. Scott McGowan, have gone beyond merely meeting the needs of counselors, they have successfully elevated the level of our profession. I, as well as NYCA, thank them for their dedication, expertise and vision. We are indebted to them.

As you read through this publication, I hope that you share my excitement and enthusiasm for the talent, variety, diversity and creativity contained in these articles written by fellow professionals. I also encourage each of you to contribute to this publication. We all have ideas, experiences, practices or research we can share that will help others in their professional development.

The strength and beauty of NYCA is the mosaic of counseling specialities it represents. Take this opportunity to explore the diversity within our ranks through *The Journal* because it is this difference that presents us with new and exciting innovations which we can share with our colleagues. To celebrate this diversity, this variety, this difference, is to acknowledge the strength of the whole - the New York Counseling Association.

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New York State Counselor Licensure: An Overview

Terry Bordan
Judith Ritterman

The history and current status of New York State counselor licensure is reviewed.

When special issues for counseling are considered by professionals in the field, the licensure movement emerges as an important theme (Ginter, 1991). In New York, the mid 1960s saw the formation of the Joint Council for Mental Health Services, heralding the licensure effort. The council served as a coalition of unlicensed mental health service providers including, among others, psychologists and psychoanalysts. Licensure was sought under an omnibus bill and although progress was achieved, the psychologists jettisoned the psychoanalysts in order to get their own single-titled bill through the legislature. As a result in 1976, the doctoral level psychologist achieved title certification while the other providers continued to be unlicensed.

In the early 1980s, the psychologists' efforts to attempt a sweeping scope of practice bill which would have prevented any other mental health professional from legally practicing in New York State, except for psychiatrists, failed. The title of a profession is legally protected by title certification, which is a form of licensure. In New York State, anyone can do the work of a psychologist, but cannot call himself/herself a "psychologist". Social workers also enjoy title certification and together with psychologists are presently seeking scope-of-practice legislation, which would protect both their titles and services. Scope-of-practice legislation, on the other hand, legally defines both the title and dimensions of the practice of a profession. This form of legislation protects both the practitioner and the consumer by defining what a practitioner can do under the law. Without this form of licensure, professions can be excluded from participating in certain private, federal, and state health care programs.

The Joint Council for Mental Health Services continues to exist and currently represents the professions of psychoanalysis, mental health counseling, pastoral counseling, marriage and family therapy, and creative arts therapy. The Joint Council supports bill # S4072/A1685, originally drafted in 1992 by the State Education Department (SED). The SED was concerned with the consumer protection issue inherent in the lack of licensure for some mental health professions.

Currently in New York State, there are four licensed mental health professions: psychiatry, psychology (doctoral level), social work, and psychiatric nursing. If a member of any of the above professions loses his/her license as a result of incompetent or unethical behavior, this person may continue practicing using any one of the unprotected titles such as "counselor" or "psychotherapist". Equally important, any person without training, education or credentials may represent himself or herself to the public as a qualified practitioner of counseling or psychotherapy without violating the law. Therefore, there is consumer endangerment until all qualified mental health professionals are licensed.

Bill # S4072/A1685, The Mental Health Practice Bill, will create a license for the new profession of mental health therapy. The professions listed above will have their own unique requirements, while sharing the title of mental health therapist. At the same time, it must be emphasized that this scope-of-practice legislation includes testing, diagnosis, and treatment. The requirements for counselors, as defined by the bill, are: 1) a masters degree in counseling or a related field including 1,000 hours of supervised experience and 2) 3,000 hours of post-masters supervised experience. These criteria represent the national standards of the American Mental Health Counseling Association and will give counselors parity with the currently licensed professions. A regulatory board, established within a year of the passage of the legislation, will more clearly define specific academic and experiential standards.

At present, there are several options that counselors can exercise in order to become qualified providers of mental health services. One avenue is for the professional to obtain a speciality certification. Many states use the standards set by The National Board of Certified Counselors (NBCC) in determining licensure criteria (Valentino, 1995). Although there is print material available from the American Association of State Counseling Boards, and the American Counseling Association has adopted model licensure guidelines, there is little other literature offering professionals workable instruction for a successful licensure effort. One exception to the above is Edgar and Davis (1983), who studied the licensure movement in Idaho and published a review of that effort.

With little antecedent to rely upon, in 1993 the leadership of the New York Mental Health Counselors' Association launched a legislative action campaign in order to facilitate the passage of the licensure bill. It was recognized that a grassroots campaign to educate every legislator to the need to address this issue would be necessary in order to make licensure a reality (Morrissey, 1995). The five professions to be licensed by the bill have education and training which would enable them to compete with the presently licensed practitioners. As of this writing, psychologists and social workers are considering a collaboration with the Joint Council.

In launching the present licensure campaign, over 2500 counselors in New York State have been contacted by the New York State Mental Health Counselors' Association to lobby their assembly people and senators in their respective 150 assembly and 61 senatorial districts. Members of the professions of the Joint Council collaborate on a district-by-district basis in the lobbying of their legislators. The list of legislators who support and cosponsor the bill continues to grow.

New York State suffers from a lack of rural and inner-city service providers (Rural Health Resource Guide, 1995). With the licensure of these five qualified professions, this and other gaps in services will begin to close. The rapidly expanding elder population is creating an increasing demand for services that the above five professions are well prepared to provide. In the provision of services to seniors, counselors represent the only mental health profession with established credentials in gerontology.

Counselors comprise the fourth largest group of mental health providers in the United States with approximately 67,000 counselors licensed in 41 states and the District of Columbia. Professional counselors comprise 57% of the mental health professionals employed in agency and organizational settings (Burtnett, 1985). Licensure will help to enhance the credibility of these New York State counselors (Momtazee, 1993) through the establishment of minimal levels of education, supervision, and ethical standards. With licensure, the consumer will have recourse to challenge incompetent and/or unethical behavior (Davis, Witmer, & Navin, 1990) on the part of these professionals.

After the licensure bill is signed into law, work will need to continue to promote professional counseling. Once licensure is successful, a bill must be drafted to amend state insurance laws to include the new profession of mental health therapy. The passage of this vendorship law is vital for the advancement and acceptance of counselors as qualified professionals in New York

State. Without it, the profession could continue to be unacceptable as service providers for insurance plans and HMOs. On the other hand, managed care companies require only a state license for admittance to provider panels.

In summation, the licensure of five more mental health professions will be advantageous for New York State. An expanded provider pool will help to keep fees and insurance rates down and offer consumers the freedom to choose from among a wide variety of mental health practitioners. With passage of the aforementioned bills, the time will come for the counseling practitioner to be afforded the professional recognition inherent in licensure, along with the requisite inclusion in the health care networks.

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The Journal for the Professional Counselor/Vol. 11, No. 1 *Spring 1996*

The Research and Publishing Process: A Rational Approach

A. Scott McGowan

The Chair of the Council of Editors, American Counseling Association, provides a rational approach to research and writing for successful publication in refereed, scholarly journals. Several key ideas, rational steps, and practical tips are offered.

Writing and conducting research can be a very emotional experience, and a very trying one, especially for the neophyte author who can be easily discouraged because of negative reviews and criticisms regarding his/her work. The budding writer has most likely spent hours exploring numerous research possibilities or topics that would be of interest to professional counselors, reviewing the literature, setting up the appropriate research design for an experimental study, identifying participants for research followed by the their actual involvement, analyzing the results, and getting down to the actual grind of sitting before the computer and putting everything in a cogent and readable fashion. We can easily convince ourselves that our product is, of course, going to be greeted with open arms by editorial board reviewers and editors. Sometimes that occurs, and the thrill of acceptance for a manuscript is an emotional high, especially when it is the first time that an author has written for publication. More often than not, however, the author will receive critiques that are less than glowing, or at least in the eyes of the writer, seem to be more discouraging than encouraging. Worse of all is to be rejected! In order to increase the chances of successful publishing and to prevent negative emotional stressors from hampering them, authors can approach the writing experience from a rational manner through the application of various techniques that I have found helpful in my own writing. These techniques, ideas, standard rules, etc., have been gleaned from a variety of sources, to wit: from my own experiences as a successful, and sometimes, not so successful researcher and writer; from my experience as an editor of several refereed journals and as Chair of the Council of Editors; and, from the writings and publications of other writers, editors, and researchers who study the science and art of successful research and writing. Not every aspect of successful writing, of course, can be covered in this particular article if I am to follow one of the key rules that can increase the chances of publication: determining the average or preferred length of articles in a targeted journal. For example, while scholarly writing differs from creative writing, that does not mean that an article need be dry and boring; this topic is covered in depth by Salomone(1993), and while I have thoughts on this matter, space limitations mean that that is a topic for another paper. In the case of this scholarly journal, that preferred length is about twenty typed pages. This question of length is addressed further on in this article. What follows are some suggestions that the prospective author may wish to consider.

Rational Step #1. Choose a Relevant Topic for Research and/or Writing

In order to have their findings published in ACA refereed journals, it is essential that researchers investigate areas that are relevant to the counseling profession and human development, that are not already over-researched, that are limited in scope, and that are actually researchable. Once the prospective author/researcher decides on the actual topic, a decision must be made regarding the type of research to be pursued: historical, descriptive, correlational, causal-comparative, or experimental. Specific competencies needed to conduct research are covered in depth by Gay(l992). Because I am not an expert in research design, I usually consult a statistical expert in order to avoid making mistakes that can lead to flaws that cannot be fixed after the fact. Articles that are topical in nature also need not be original; what must be original is the author's insight that can provide a different or fresh or enlightening view of the topic. Research enhances the scholarly base of the counseling profession and while a research area is not one that necessarily must lend itself to immediate application in the field, at the very minimum it should add to our knowledge base and move the profession forward.

Despite the belief of many, most research topics are not original, rather they are based on previous research and tend to build on that base, resulting, hopefully, in an increase in our knowledge. According to Heppner, Kivlighan and Wampold [1992):

> Typically, our research proceeds by adding one or two new pieces of information per study. Thus, a researcher might extend a previous study by adding one or two new constructs or developing a new assessment instrument to operationalize a construct ...In short, it is essential to focus on investigation of just a few constructs, and not to try to do too much in developing an 'original

> contribution.' Most often our knowledge bases in counseling increase in small steps by building only slightly on previous research (p. 34).

Hence, the prospective writer should know that it is not necessary to be an original thinker in order to conduct successful research or to develop a publishable topic. What is necessary, however, is for the researcher to do a thorough review of the literature, a discussion of which follows.

Rational Step #2. Conduct a Current, Relevant, Concise, and Representative Literature Review

A thorough review of the literature is essential even for "In the Field," very practical articles - otherwise, the article becomes merely an opinion piece. Such articles do have their places, but they are more appropriate for magazines or newsletters rather than refereed scholarly journals. As a young doctoral candidate in 1973, I spent well over a month in the Fordham University library in Manhattan doing a review of the literature for my dissertation. In those days, there were no computer searches which now, in a matter of hours, can pin-point key studies and articles relevant to a particular topic. Given the technology of today, an author can quickly identify and obtain copies of works that both support or dispute a particular point of view. Unless a reference is directly pertinent to the study or article, it should be no more than five years old. Authors are expected to do an exhaustive review of the literature, but this does not mean that every article or study is to be cited in the actual text. Given the limited space in journals and the need to be as concise as possible, a representative sample of references is what is required. Indeed, listing a string of references to support one's research or point of view is distracting to the reader and rather than enhancing understanding can actually cloud the issue. According to the APA style manual (1994), "The reference list should be succinct, not exhaustive; simply provide sufficient references to support your research. Choose references judiciously and cite them accurately" p. 20. The reference list must correctly mirror citations in the body of the manuscript. Attention to this detail is imperative in order to avoid rejection or delays in publication of a manuscript. Ritchie (1995) stated that "Used properly, literature reviews greatly enhance the findings of an article by putting them into the context of previous research. Insufficient or inaccurate literature reviews not only detract from the article, they can make it unpublishable" (p.3).

Rational Step #3. Follow the Guidelines of the Targeted Journal Carefully.

It is critical that the author reads and follows carefully the guidelines of the targeted journal. Generally, national ACA journals, and ACA branch journals (e.g, *The Journal for the Professional Counselor*) have their own specific guidelines that authors are expected to follow. As an editor, I have returned manuscripts without a review when the writer neglects to follow these published guidelines. For example, I have recently sent manuscripts back to authors because they did not send me the required three copies of their manuscripts. There is a reason for requiring this number: one copy is kept by the editor in the file and the other two are sent to reviewers for a blind review. Editors do not have the time to copy manuscripts for writers. It would be an imposition to expect editors to do so. By and large, however, such authors are not being presumptuous, they have simply not read the guidelines. Such guidelines are not usually published in every edition of a journal, but periodically. Therefore, it is incumbent upon prospective writers to research back issues if the current edition does not include the guidelines.

Rational Step #4. Thoroughly familiarize yourself with and use the *Publication Manual of the American Psychological Association, 4th edition.*

All ACA national journals and ACA branch journals use this manual as their Bible! It is essential that authors use the fourth edition published in 1994. Unfortunately, some authors are still following the third edition version. Again, manuscripts will not be rejected, except in the most blatant of cases, just because the author has not used the latest version or the manual, but correcting manuscripts of authors who do not use the current edition is time-consuming for editors and review board members and does not lend itself to a positive view.

Rational Step #5. Determine Preferred or Average Length of Manuscripts for a Targeted Journal

In a survey of 50 refereed educational journals. Henson (1995) found that 73.7% indicated that a 12-page manuscript was the preferred length. Because each journal varies, it is important for authors to read the guidelines which generally state the maximum pages that the editor will accept. If an author has sufficient reasons for submitting a paper which exceeds this maximum length, then it is incumbent upon him/her to contact the editor prior to mailing it. Again, I would emphasize that a researcher/writer would increase the likelihood of acceptance, if the submitted piece mirrors the average length of published articles in a particular journal. A practical reason is that journals have limited space available. However, there is another more compelling reason why this is so: as a journal reader myself, I simply do not have the time to read long dissertations - selfishly, I need to quickly assess the essence of a writer's findings, ideas, and implications for me as both a counselor and as a counselor educator. I want information that either increases my understanding of the human condition or gives me some practical suggestions that can be implemented. Even though I publish poetry in *The Journal of Humanistic Education and Development* on occasion, and, indeed, it is appropriate because the journal does reflect our humanistic bent, by and large, I turn to other sources than refereed journals for artistic, entertaining, or literary fulfillment. A concise and straightforward manuscript will, in general, be more acceptable to reviewers and editors. In short, generally avoid emotionally charged pieces for more rationally-based ones.

Rational Step #6: Match the Manuscript Topic with the Appropriate Journal

One reason why I as an Editor would reject a manuscript is because the topic is not appropriate for *The Journal of Humanistic Education and Development*. Writers and researchers can save themselves much time and emotional energy by matching the topic of the manuscript with the goals of the association that publishes a particular journal. For example, if the readership consists primarily of school counselors and the manuscript is dedicated to some aspect of developmental guidance in the classroom, the author would be wise to send it to *The School Counselor* rather than to *The Journal of Mental Health Counseling*.

Rational Step #7: Target the Primary Journal and Identify Secondary Ones

Acceptance rates of journals can vary even among national refereed journals and there are stringent space limitations. Therefore, it is extremely important for the writer to investigate other related journals. If the focus of a particular manuscript dealt with career decision-making, I may, for example. target the *Career Development Quarterly*, but I would most certainly also have several other perspective journals dealing with such issues as alternate choices in case my first choice rejected my manuscript. Another approach and excellent alternatives, as I pointed out in a 1994 article which addressed this topic, are branch journals such as *The Journal for the Professional Counselor*, an American Counseling Association award winner for excellence. Generally, the editors of these branch journals are not as inundated with submitted manuscripts as editors of national journals and, although their time is limited as well, they often are more open to working with a prospective author in order to make a manuscript publishable. Therefore, while the reception of a rejection letter can devastate an author, having an alternate journal chosen can be an impetus for the author to commence working immediately to prepare for a new submission.

Rational Step #8. Package the Manuscript for a Good First Impression

While the content of a manuscript is its heart and soul, and it is that which really determines whether it will be published, first impressions are important when prospective authors submit manuscripts to journal editors. While the following considerations may be viewed as superficial, and in some ways they are, nevertheless, they can only enhance the chances of a positive reception when authors are diligent about the details of submission techniques. If the author believes that his/her manuscript is important enough for publication and consideration by the readership (professional counselors), certainly he/she will want to package it in a professional manner.

An introductory letter should be submitted with the manuscript. This letter should include the name of the manuscript, a sentence or two describing the content, and a brief statement as to the reasons why the readership of the particular article would benefit from its publication. In addition to the address of the author(s), telephone numbers, FAX and E-Mail addresses should be included. Manuscripts are not rejected simply because the author failed to send an introductory letter, but doing so may give the impression of a careless or too-casual writer. Also, such a letter may be helpful to an editor the same way that an introductory letter is when it is sent along with a resume in that it is helpful in that it allows a quick assessment of the appropriateness of a manuscript for the particular journal; the editor, of course, will check the manuscript itself for appropriateness, but a letter is an extra bit of help in commencing the review process.

In order to avoid other delays, the author should ensure that he/she has the current editor's name and address. Periodically, manuscripts are forwarded to me from the former editor because the author has not taken the time to obtain a current copy of the journal which lists the name of the editor. Authors should also be aware that printed guides to refereed journals, while important, are not always up-to-date, especially with regard to editorships which generally change every three years.

While in the process of writing this article, I received a manuscript that had been folded in a regular legal size envelope with postage due, one copy only, with a hand written note asking that it be printed in our national refereed journal. Other than the fact that the article failed to even approach APA standards, lacked even one reference which made it no more than an opinion piece, and dealt with a topic that had nothing to do with the interests of the readership of our journal, I found it incredible that an author would be so careless and casual. This does sound judgmental except that the article was sent by a full professor who should know better. I value both my time and that of reviewers. and I especially respect the fact that the reviewers are unpaid colleagues who deserve at least minimal attention by the author to proper procedure when submitting a manuscript. The manuscript, by the way, was returned to the author without a review.

Rational Step #9: Rewrite and Resubmit If invited

Most articles and studies are not accepted outright. Indeed, I have personally accepted only two such pieces which did not require any changes at all. Sometimes the author who is invited to rewrite and resubmit an article becomes so discouraged that he/she simply gives up and consigns the manuscript to the dust bin; this is a mistake. In Henson's (1995) survey, he found that for authors who rewrote and resubmitted, the average chance of final acceptance doubled. The writer who receives such an invitation and is willing to make the requested revisions and corrections can increase the chance of final acceptance and also shorten the time of waiting for a response through the following technique: in addition to the actual manuscript changes, I find that the researcher/writer who submits a separate letter that answers carefully and in detail each criticism is more likely to receive positive reviews from the reviewers the second time. Not only does such a device clarify what has actually been done, but it also saves the reviewers much time. Additionally, if there is a reason why the author cannot or will not make a requested change, this provides an opportunity to defend a particular stance or point of view; if the arguments/reasons make sense, most reviewers will be accepting.

Rational Step #10: Learn to Accept Rejection — What to Do and What Not to Do

I had the misfortune to have one manuscript rejected by four refereed journals! Yes, I was upset with every rejection letter. Indeed, one reviewer's comments really seemed ridiculous: in short, the reviewer stated that "the study is relevant, but so what!" How does one respond to something like that? For one thing, I did not write a letter of rage to the editor for several reasons: it would have been unprofessional. It would have been counter-productive, and it would been a waste of time. From a practical point of view, it was very likely that I would be sending other manuscripts to this same editor sometime in the future. Although editors are supposed to be completely objective and rational, we are still human beings with failings. An angry letter may have allowed me to vent my frustration, but I also could have made an enemy. What I did find with that apparently irrational remark was a grain of hope: the study was relevant! Thinking back on that incident, I realized that even good manuscripts are rejected by national journals simply because one is competing with hundreds of others for limited journal space. As a national editor now, I sometimes have to reject an article, not because it is not publishable, but because there are other manuscripts that would be of greater value to our readership. In my own case described above, I found that with every negative review that necessitated a rewrite, the manuscript improved. Each rejection seemed less harsh, primarily because each time I improved it. The study was finally published in a national refereed journal.

Authors who receive rejection letters, but who believe that the manuscript is important, should address the criticisms and make the suggested corrections, but should not resubmit to the same journal. It is much more practical and less emotionally damaging to resubmit to another journal rather than risking another rejection because once an editor has made up his/her mind, that is really it! Editors simply do not have the time or inclination to revisit an already rejected manuscript. Only once have I done so. The primary author called me after she received the rejection letter and the critiqued manuscript. To her great dismay, she discovered that her graduate assistant had submitted not the final version of the manuscript to me, but, instead, had pulled up the first draft on the computer and had printed that version! This was a careless and almost fatal mistake. Many busy editors would quite properly have refused to have taken another look. However, since the author blamed herself for not checking the manuscript just prior to mailing and since other secondary authors were involved, I agreed to a reconsideration. The manuscript was later accepted, after another major rewrite.

Conclusion

The prospective writer/researcher who follows the above suggestions cannot be guaranteed publication in ACA or other refereed journals, but the chances of eventual publication can be increased if the author does so. To have an article or research study accepted by a refereed, scholarly journal is most satisfying. Having one's work rejected is most certainly not satisfactory and can wreck havoc on the ego! However, unless the individual author really cannot write clearly or is so lacking in the basic knowledge of the counseling profession, there really is hope for publication if one persists and is willing to accept the criticism of his/her peers. Scholarship, diligence, persistence, acceptance of criticism, coupled with the courage and wherewithal to address a blindly reviewed critiqued manuscript in a rational manner, may very well result in a publishable manuscript. I challenge professional counselors in all settings, especially the practitioners to be risk-takers and to commence research, start writing, and share the wealth of knowledge they possess. Such risk-taking can only advance the profession and add to our knowledge base.

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> "*A wise man (sic) will make more opportunities than he (sic) finds.*"
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> –Francis Bacon, *Essays*

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“*Character is simply habit long continued.*”

–Plutarch, Morals

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The Student-Athlete Dichotomy: Helping Students Fulfill Their Dual Roles

Frank Brady

This article addresses the role of intercollegiate athletics in education. Attention is focused on a number of the problems that result from the uneasy coexistence of athletics and academics. The article highlights the attempts of the NCAA to redress the imbalance between sports and education. The role of counselors is given consideration in the hope that they will assist student-athletes in adequately fulfilling their dual roles.

Introduction

Intercollegiate sports competition has long been considered an integral part of the American educational system. The putative positive values of sports participation have been persistently perpetuated and promulgated to legitimize its presence in educational institutions. Athletics have traditionally been assumed to impact in positive ways on the overall socialization and education of the individual. The aim of the National Collegiate Athletic Association (NCAA) is to "maintain intercollegiate athletics as an integral part of the educational program and the athlete as an integral part of the student body and by so doing, retain a clear line of demarcation between intercollegiate athletics and professional sports" (NCAA, 195, p. 1). The NCAA's manual also proclaims that athletic participation is supposed to be an avocation and that the student-athlete engages in sports for educational, physical, mental, and social benefits. Further, the manual states that "the mission and goals of the athletic program are to relate clearly to the mission of the institution and also to support the educational objectives and academic progress of student-athletes" (p. 402). Despite the plausible positive proclamations of the NCAA that a synergistic or symbiotic relationship exists between academic and athletics, there is much evidence that such mutualism may not exist; in fact, the parallel pursuit of academics and athletics at the collegiate level may be antagonistic or antithetical to each other (Scott, 1971; Edwards, 1973, 1986; Underwood, 1980; Frey and Massengale, 1988; Brownee and Linnon, 1990; Sperber, 1990; Bailey and Littleton, 1991). It would appear that the student-athlete may be confronted by role conflict or role strain when attempting to fulfill the often onerous and conflicting multiple demands of being simultaneously a student and an athlete. In this situation, Figone (1994) noted that student-athletes either fall short of the expectancies of both roles, or they devote more time and energy toward one role, thereby neglecting the other and consequently creating role retreatism. Howard (1993) stressed that student-athletes should be students first and athletes second. However, in many institutions, the reverse was true.

Athletics in Academe

Loy, McPherson, and Kenyon (1978) noted that the role of sport may be akin to a double-edged sword within an educational institution, thereby precipitating conflicting and undermining purposes. According to them, participation in sports may be instrumental in raising educational aspirations, encouraging academic achievement, fostering social integration and finally serving as a catalyst for upward social mobility. On the other hand, they argued that participation in sports may be dysfunctional, diversionary and detrimental to the goals of education. Coleman (1961) in a classic study, noted that over-emphasis on athletics diverts the energies and attention of students away from academic affairs. Coleman also stressed that athletic achievement is reinforced and rewarded more than academic success. Athletes are accorded more popularity and prestige as they are perceived to be part of the "leading crowd" according to Coleman. Spady (1970), in attempting to delineate the nexus between sport and education, cautioned that while sports participation appeared to stimulate aspirations by virtue of its greater visibility and transitory status rewards, sports participation does not by itself provide the skills and resources necessary to facilitate subsequent success in college. The student athletes, according to Spady, often are deluded with exaggerated educational goals and inflated status perceptions. These perceptions are frequently accompanied by marginal intelligence which is exacerbated by a weak academic commitment. Participation in sports may be viewed by some students as an alternative to, rather than complementary to, the academic mission of the school according to Spady. Landers, Feltz, Obermeier, and Brouse (1978) noted that intensive participation in athletics, often at the expense of other extracurricular activities, may hinder the fostering of positive academic attitudes and interpersonal skills. Figone (1994) stressed that it was virtually impossible for a student-athlete to obtain a quality education, given the tremendous demands and the "psychic drain" which he or she must endure. Coleman (1961), Scott (1971), Edwards (1973), and Underwood (1980) did much to debunk the functionalist perspective of the role of sport in education; instead, these authors accentuated the dysfunctional role as the more salient and with the more serious consequences for the student-athlete. As a result of numerous exposés, the problematic nature of athletics within educational institutions has been extensively publicized (Edwards, 1986; Lapchick, 1986; Sanoff and Johnson, 1986; Frey and Massengale, 1988; Funk, 1991).

Evolution of Collegiate Sports

In an attempt to track and trace the genesis of the dysfunctional element of collegiate sports, Hart-Nibbrig and Cottingham (1986) postulated the twin trends of commercialization and athleticism as responsible for precipitating many of the current problems in collegiate sports. The continuing commercialization of college sports eroded the amateur ethos, and consequently collegiate sports evolved to resemble the conduct of professional sports. Frey and Massengale (1988) noted that the transition from an amateur to a professional model of sports resulted in educational goals being displaced while "priorities became confused and transformed to the point of institutionalized helplessness" (p. 42). According to Frey and Massengale, the more commodified, formalized and professionalized collegiate sports became, the less applicable were traditional educational values. Character building and enhancing education were replaced as the guiding values by the struggle for power, profit and prestige. Sports were no longer viewed as a healthy diversion from the rigors of academic work but as the path to fame and fortune.

The commercialization of collegiate sports was compounded by a profound athleticism, the second major trend that evolved according to Hart-Nibbrig and Cottingham (1986). Athleticism is characterized by a pervasive and persistent emphasis on winning, almost at any cost. Greater athleticism begets more intensive and extensive training and becomes an almost all-consuming activity for the student-athlete. The twin trends of commercialization and athleticism engendered a displacement of values in the educational milieu, with academic values being eroded and demoted as athletic ones were promoted and given primacy. This displacement led to an ideological discrepancy between the prevailing sports culture and the expressed justification of the educational value of athletics.

Bailey and Littleton (1991) stressed that the relationship between athletics and academics resulted in an uneasy coexistence, and propelled them on a collision course. Given the power and potency of the prevailing value system that evolved in collegiate sports, where academic interests tended to be subverted or circumvented, it is relatively easy to understand some of the well-publicized abuses that plagued educational institutions, especially the brazen exploitation of the student-athlete and the blatant disregard and denigration of the athlete's academic interests (Funk, 1991). Nelson (1983) noted that student-athletes become prisoners of their physical talents and become stunted in other dimensions of their being: many student athletes were scholastically inadequate to begin with, while others were given little assistance in obtaining a meaningful education.

Maloney and McCormick (1992) noted that students-athletes, specifically in the revenue producing sports of basketball and football, have markedly weaker academic credentials; their Scholastic Aptitude Test scores were almost 150 points less while their high school rank was approximately 20% lower than that of the general student body. Sperber (1990) noted that "good academic standing" was camouflaged and maintained by having students register in "hideaway curricula" and major in "eligibility." Lapchick (1986) noted that as a result of institutional pressure to maintain eligibility, student athletes were often encouraged to take the path of least effort by enrolling in many courses that made few if any academic demands upon them. Physical education and recreational courses often accounted for a disproportionately large source of credits for many student-athletes. In addition, the substantially significant disparities in the grade point average achieved in these courses helped mask or attenuate the markedly lower grades in other more academic subjects. However, maintaining eligibility is not synonymous with gaining a meaningful education. The pejorative stereotype of the dumb jock becomes a self-fulfilling prophecy that has been insidiously and systematically created by a system that gives priority status to the athlete while a peripheral and perfunctory role to that of the student. The athletic scholarship reinforces the primacy of the athletic role. Funk (1991) cautioned that the pervasiveness of the negative prioritization of academics has serious and long -lasting consequences for the student-athlete.

Impetus for Reform

Against this background and amid calls for greater accountability, the NCAA implemented Proposition 48, a measure that raised eligibility requirements for freshmen student-athletes. The rule stipulated in 1986, that athletes on scholarship must obtain a minimum of 700 on the Scholastic Aptitude Test or a score of 15 on the American Colleges Test, in addition to achieving a 2.0 GPA in eleven high school core curriculum subjects that included English, mathematics, and the social and physical sciences. Despite the fact that these criteria were substantially below that required of the general student body and amidst the dilemmas and clamor about the bias of standardized tests against some ethnic groups, Proposition 48 would eventually become the foundation and impetus for future reform in collegiate sports.

Proposition 48 marked a watershed in attempting to staunch the tide of abuses by rectifying some of the most egregious ones. It also symbolized the concern for more academic integrity by tightening eligibility requirements. Sperber (1990) noted that the NCAA's entrance requirements legitimized the student-athlete concept by "putting the student back into the student-athlete" (p. 217).

Graduation rates of student-athletes have received the most publicity as a tangible symbol of an athletic program's commitment to academics. A number of studies assert that athletes graduate at a higher rate than the general student body. However, Funk (1991) debunks this claim and issued the caveat that many of these studies contained serious methodological flaws. In 1990, the NCAA drafted guidelines and specific reporting procedures that would alleviate previous problems. Graduation rates have to be decomposed by sport and gender and compared with those of the general student body.

In 1994, the NCAA continued to show its reform zeal and its concern for greater academic integrity by stipulating that only student-athletes with reasonable expectations of graduating should be admitted. Further, the NCAA also stated that if the graduation rates of student athletes were substantially lower than the rest of the student body, then the disparity should be addressed by the appropriate institutional authorities under clearly established and approved policies. The NCAA also recognized that student-athletes may have some special academic needs, and they urged that academic support services be provided to meet these needs. The support services should be approved and reviewed periodically by academic authorities outside the department of athletics. Taken together, these recent changes in NCAA policies amount to a tacit admission that the university has an ethical responsibility to provide adequate academic support for the student-athlete, whose athletic accomplishments mean so much to the university. No longer should student-athletes sacrifice academic achievement in the transitory pursuit of athletic excellence.

The momentum of reform continues. The NCAA will implement Proposition 16 in 1996, which will make academic requirements more rigorous for the potential student-athlete: a GPA of 2.5 in thirteen academic subjects of the high school core curriculum, with the two additional courses being in English and in either mathematics or the natural sciences. A modified indexing relating the GPA, the SAT and ACT has been developed by the NCAA to determine eligibility. Student athletes will also be required to complete a progressive percentage of courses required for graduation in their specific degree programs. This proposal continues to be a step in the right direction and will help repair and redress some of the damage done to academics in endorsing the supremacy of athletics over academics throughout the latter half of this century. It will convey to student-athletes that they are expected to develop academically as well as athletically and that athletic skills alone are not sufficient to go to college. Also a student-athlete fulfilling the more stringent requirements will be scholastically better prepared than many of athletic predecessors and thus be equipped to adapt better to the demands of the role of the student-athlete.

However, raising admissions standards with the hope of improving GPAs and graduation rates only partially addresses the plight of the student-athlete. Walter, Smith, Hoey and Wilhelm (1987) stated that it is much simpler to alter admission standards than it is to monitor the education process. These authors suggest that efforts to influence academic success should be made through mediating variables such as "instructional effectiveness, the provision of a strong academic support program, attitudinal variables," such as the apparent absence of a need for a degree among those who expect to become athletes. These variables are subject to modification after the student arrives on campus, and they also distribute the pressure for achievement between the institution and the student. Although limiting inputs to improve outputs is commendable, the product may also be favorably altered through manipulating the process. Kirschenbaum and Perri (1982) noted that such programs have a reasonably successful history of raising student learning skills to ameliorate previous deficits in education.

The Role of the Counselor and the Student-Athlete

Ruscella (1993) noted that colleges and universities have historically identified segments of the student population as being in need of specialized services; unfortunately, the unique needs of the student-athletes have been generally ignored or given token lip service at best. Lanning (1982) noted that "privileged groups" such as athletes, face personal, academic and vocational problems unique to them in addition to the pressures and problems that students confront in general. Lanning also noted that society had difficulty in perceiving the pampered and privileged few as suffering from any privation. The special and preferential treatment accorded to athletes produces additional pressures and problems not encountered by their nonathletic peers. Sedlacek and Adams-Gaston (1992) stressed that it might be feasible to conceptualize student-athletes as nontraditional students as they tend to have a unique culture and set of experiences that demarcate and differentiate them from other students. Kirk and Kirk (1993), Parham (1993), and Koehler (1996) warned that student-athletes should be categorized as "at risk" students as they are vulnerable to exploitation and failure to obtain an adequate education. Sowa and Gressard (1983) noted that the situation of student-athletes often creates a seductive environment of entitlement, permissiveness, dependence and irresponsibility. An excessive sense of entitlement may limit individuals' full development academically, socially, and emotionally, as they do not expect to be held accountable for their actions. Irrational beliefs are fostered: "things will be taken care of because I am special." This faulty world view generalization translates into a myriad and matrix of academic, social and emotional problems. Athletes succumb to the stifling and stunting effects of a rigidly controlled and overprotective environment. Consequently student-athletes may not be empowered to act responsibly and reasonably on their own.

Counseling the Perspective College Athlete

The counselor must play a pivotal role in steering the young athlete towards a college that matches his or her academic as well as athletic needs. A peripheral role for the conselor here must be avoided! Some unscrupulous coaches seem to offer irresistible incentives to highly impressionable and often gullible youngsters to recruit them to their campuses. The counselor must assist athletes in objectively weighing the relative merits of these institutions. The intense pressure to produce winning programs often compels coaches to recruit academically under-prepared or scholastically marginal blue chip athletes who will be successful athletically, but will have little chance of graduating (Kirk & Kirk, 1993). The NCAA now stipulates that the graduation rates of scholarship athletes be reported separately and by race, gender and sport. The graduation rates of athletes from a particular university or college is a good barometer of that institution's commitment to academic excellence and integrity. Counselors should discourage athletes from attending colleges that have low graduation rates for student athletes. In addition, the counselor should provide the prospective student with pertinent information regarding programs, support services, placement possibilities and the prestige or ranking of the school. The counselor can act as a counterbalance between the athlete and the coach and also assist the athlete in maintaining a balance perspective on their dual roles of athlete and student. In any sphere a good start is an advantage, but for the student-athlete choosing the best college is a major one.

Academic Counseling of the Student-Athlete

Pascarella, Bohr, Nora and Terenzini (1994) and Maloney and McCormick (1992) noted that student athletes commence college with weaker academic credentials and that the educational deficit tends to be amplified rather than ameliorated as they pass through college. Pascarella et al. noted that participation in the revenue producing sports of basketball and football was negatively associated with end of year freshmen scores in mathematics and reading. These researchers noted that first year students took a much greater proportion of their course work in applied or preprofessional areas. However, there is much evidence to indicate that these initial disadvantages become cumulative and more pronounced over time unless interventions are made to arrest and then ameliorate the deficit.

Nelson (1982) found that student-athletes who declared a major earlier received higher grades and reported being happier in their academic affairs. Counselors should encourage students to declare a major and concomitantly direct them into more courses in the humanities, social sciences, physical and natural sciences. Participation in more academic type courses would facilitate the fledgling reading and quantitative skills of the student-athletes. Further, the poorer reading skills of the student-athletes were compounded as they also reported reading fewer texts or assigned readings. Pascarella et al. attributed the lack of adequate reading habits to the athletic subculture that attaches little value to academic achievement. Maloney and McCormick (1992) concurred with Pascarella et al. (1994) that athletes tend to have poorer academic backgrounds and consequently achieve lower grades. To compensate, the student-athletes take easier courses to mitigate the negative effects. However, this stopgap approach is short-sighted and self-delusional as it sabotages the educational process. Student-athletes must realize that they are students first and be counseled to enroll in bona fide academic courses so as to make satisfactory progress toward a degree. Education should obliterate shortcomings rather than obscure and obfuscate them with soft options.

The Counselor and the Athletic Identity

Athletic participation has long been regarded as playing a key role in developing a person's identity (Coleman, 1961). Danish, Petitpas, & Dale (1993) noted that identity is a product of past experiences and feedback from significant others. Many highly skilled athletes have been continually rewarded and reinforced for their accomplishments, and as a result their identity becomes exclusively grounded in athletics. Koehler (1996) stressed that athletic scholarship crystallizes their identity and validates their athletic prowess. Wooten (1994) held that excessive identification with the athletic role produces a premature and foreclosed identity. Marcia (1966) described foreclosures as occurring when a commitment to an activity is made prematurely without sufficient exploration of one's needs and values. Student-athletes may not attempt to achieve academic success. Burke (1993) noted that student-athletes may experience dissonance in their self-esteem as they manipulate the roles of student and athlete. Fulfilling the athletic role may enhance feelings of self-worth while attempting to fulfill the demands of the student's role may engender feelings of inferiority. In response, the student athlete may withdraw from the academic role, convincing himself/herself that education is unimportant. A prematurely foreclosed identity becomes problematic when it hinders the process of exploration whereby individuals acquire additional competencies through interactions with others. Counselors should attempt to help student-athletes becomes multi-dimensional, otherwise they may prematurely commit themselves to unrealistic objectives and life aspirations.

The Role of Counselor and Career Development

As many student-athletes educational prospects are greatly hampered by their adoption of a prematurely foreclosed identity, the role of the counselor in career development and planning has added significance. Edwards (1986), Stiers (1995) and Koehler (1996) acknowledged that many student-athletes were seriously deluded by the "pro myth" as they intend to extend their athletic careers into the professional ranks. Many of these students have unrealistic notions about their athletic potential and prospects and sports are viewed as the avenue to fame and fortune. The myopic belief in the "pro myth" gravely undermines the pursuit of educational goals and ultimately results in severe disenchantment from the sport because the student-athlete has neither a professional contract or a meaningful education to which to resort. Moran (1995) noted that illusion of the pro myth is more alluring than ever as professional teams spring up in Europe and South Africa. The harsh reality is that the odds are about 100 to 1 against a high school athlete playing in college, while a meager 2% sign a professional contract, with many of those having a responsibility to present a "reality check" to these athletes regarding their professional athletic prospects. The tendency to have unreasonable expectations is especially prevalent among minority students as too many students are lost educationally while trying to live an ever-fleeting dream. Above all, they must realize that sports are not the way to success or the way out of poverty. Sports as an avenue of upward social mobility is largely a myth, except for the elite few. Counselors should encourage student-athletes to maximize the student role as that is where their greatest chance of success lies.

The Counselor and Athletic Subculture

There are many aspects of the athletic subculture that are inimical to the pursuit of academic goals. The widespread use of alcohol and a sense of excessive entitlement are two of the more widely publicized elements that are deemed to have far-reaching repercussions and ramifications for the student-athlete. Excessive entitlement is denoted by having exaggerated ideas and claims as to which a person has a right (Kriegman, 1988). Many student-athletes abrogate to others responsibility for their personal decision making, such as selecting an academic major, class schedules and the task of fulfilling many of the demands of their academic and personal lives (Wooten, 1994). The highly recruited, blue-chip athlete is especially vulnerable and often expects excessive entitlement as the norm in the athletic milieu. However, an overdeveloped sense of entitlement can retard an individual's development academically, socially, and emotionally. The counselor should focus on the dysfunctional aspect of entitlement and the probable consequences of maintaining such a perception (e.g., school failure, legal and moral problems). The athlete should be assisted in developing a more realistic appraisal of his/her situation.

Academic problems of student-athletes are frequently partially attributed to the heavy time demands of their particular sports. In addition, the student-athlete is often considered to be deficient in time management. A recent study quoted by Lipsyte (1995) indicated that college athletes were more likely to be binge drinkers than other students. A staggering 61% of the student athletes reported binge drinking by comparison to 43% of the general student body. Given the time constraints imposed by the athletic role, excessive drinking will further impinge upon and impair the student role. The author also noted that the "second-hand effects" may be the most troubling as alcohol has been a factor in much of college crime. Counselors face a difficult task as drinking is a highly social activity on campuses, although a pernicious part of campus culture.

Conclusion

Gifted high school athletes are recruited to colleges with strong athletic programs. Collegiate sports programs and student-athletes are supposed to engage in a mutually beneficial relationship. Athletes ply their skills while the university is obliged to provide an education. Despite the numerous benefits of this association, the potential exploitation of the student-athlete has long been a serious problem. Propositions 48 and 16 by the NCAA were attempts to redress the imbalance in the academic athletic nexus. The policy of raising the quality of the input so as to raise the output would appear to be prima facia sound strategy. However, there are many intervening and mediating variables that influence the process that leads to the product. Counselors sensitive to the unique needs of student-athletes are charged with optimizing the student role. The confluence of a better scholastically prepared student-athlete and a counselor attuned to their special needs may abolish the pejorative dumb jock syndrome or stereotype. The student will be then firmly entrenched in the student-athlete role rather than an uneasy appendage.

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Adolescent Egocentrism and Its Relationship to HIV and AIDS

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This article examines the relationship between adolescent egocentrism and the high risk behaviors that can ultimately lead to HIV and AIDS. Research has shown an alarming lack of correlation between teenagers' knowledge of AIDS prevention and their practice of safer sex. Attitudes of invulnerability, such as "it won't happen to me," coupled with the eight to eleven year delay in the appearance of visible symptoms of the disease, promote a false sense of security that puts many adolescents at extreme risk for acquiring HIV and AIDS.

This article discusses the relationship between adolescent egocentrism and AIDS. Egocentrism evolves from Piaget's formal operations theory and has two constructs: imaginary audience and personal fable. High risk behaviors that lead to the acquisition of AIDS are addressed and a connection drawn to adolescent egocentrism. Finally, implications for clinical practice are discussed.

When David Elkind introduced his theory of adolescent egocentrism in 1967, he provided a framework for understanding certain adolescent behaviors that many describe as reckless, uncontrollable, or without thought. These behaviors have inspired others to further study the concept of egocentrism (de Rosenroll, 1987; Dolcini, Cohn, Adler, Millstein, Irwin, Kegeles, & Stone, 1989; Enright, Shukla & Lapsley, 1980; Hudson & Gray, 1986; Lapsley, 1993; Lapsley, Jackson, Rice, & Shadid, 1988; Muuss, 1982; Tice, Buder, & Baumeister, 1985). As factors for high risk behaviors, adolescent egocentrism and social cognition are also well documented in the research literature (Arnett, 1989; Baizerman, 1977; Blos, 1962; Brown & Greenspan, 1983; Chilman, 1983; Furby & Beyth-Marom, 1990; Gershenson & Handler, 1985; Green, Morton, Cornell, & Jones, 1986; Muuss, 1982). Sunenblick (1988) studied adolescents' cognitive and emotional development in relation to knowledge of AIDS and the corresponding vulnerability to AIDS. However, there is little information that connects egocentric thinking in adolescence to contracting HIV and AIDS.

Formal Operations

Egocentrism originally derived from Piaget's theory of cognitive development (Muuss, 1982). It is necessary then, when considering adolescent egocentrism, to examine Piaget's stage of formal operations. This stage begins at about age eleven and is fully established by age sixteen (Inhelder & Piaget, 1958; Piaget, 1957). Individual mental abilities, at the formal level of thinking, allow the person to have task-specific thoughts (Manaster, 1977). As a result, the formal operations stage is seen to have a social element, which can affect adolescents' thoughts about society as a whole, other individuals, and themselves.

Adolescents make a transition from concrete operational to formal operational thinking (de Rosenroll, 1987). As a result, they experience new and different ideas, and learn to think abstractly and reason hypothetically. This affords the adolescent a "broader perspective for reinforcing his or her view of self and the world" (Manaster, 1977, p. 46). Formal operations (de Rosenroll, 1987; Elkind, 1978; Riley, Adams, & Nielsen, 1984) allow youth the capability to consider what other people might be thinking.

In addition, Manaster points out that the results of formal operational thought lead young people to continually test the validity of their new ideas. He also states that the "adolescent coming into formal operations has not spent much time or effort considering the kind of person he [sic] might be, could be, or should be in light of a full range of possible selves" (1977, p. 4). Inevitably, then, adolescence is one of the more challenging stages in the life span. Adding to the challenge at puberty, the adolescent experiences emotional and physical changes that accompany growth in cognitive development. These overwhelming physical changes bring about the most change in thought (Elkind, 1981). One result is adolescent egocentrism.

Adolescent Egocentrism

Adolescent egocentrism (Elkind, 1969) resulting from formal operational thought and physiological changes causes adolescents to think that behavior and appearance are as significant to others as to themselves. The formal operations stage of development demands young people to test their given thoughts against reality. However, although adolescents have the mental abilities to test assumptions, they lack the motivation to do so. They are so engrossed in their own physical and emotional changes that they seldom inquire what others think about them (Elkind, 1979).

Although this is the stage of development where experimental thinking occurs, the egocentrism is dominant. The adolescent forgoes reality testing and assumes that what is actually universal to humanity is a unique experience. Two constructs make up this egocentrism: the imaginary audience and the personal fable.

The imaginary audience (Elkind, 1969; Muuse, 1982) is essentially a manifestation of the adolescents' struggle to differentiate between their own preoccupations and what others may be thinking about them. This may help to explain adolescents' feelings of self-consciousness (Cohn, Millstein, Irwin, Adler, Kegeles, Dolcini, & Stone, 1988). The youth who spends hours endlessly combing his or her hair is convinced that other people will notice every strand that is out of place. Adolescents essentially put themselves on stage, where they feel scrutinized by the world. In reality, they are presuming they are being judged by their own externally projected standards.

Because these young people feel that they are the center of attention, they also feel special and unique. Elkind refers to this feeling of uniqueness as the personal fable. Adolescents overdifferentiate these feelings, believing them to be real and unique to themselves. They perceive that only they can experience such unparalleled behaviors, thoughts, and feelings. A classic example is the youth whose parents "do not understand what it is like to be in love".

Both imaginary audience and personal fable can result in unnecessary risk taking, although the personal fable will more often yield perilous behaviors. Elkind (1981) points out that if the personal fable is taken too seriously, the individual may pursue certain self-destructive behaviors, such as unprotected sex or drug abuse. Young people who perceive themselves and their behaviors as unique will also have feelings of immortality and indestructibility. This personal sense of invulnerability (Rotheram-Borus & Koopman, 1991a; Sunenblick, 1988) arising from the personal fable (Arnett, 1989; Blos, 1962) gives adolescents a false sense of power that can cause serious repercussions.

Since the personal fable can be quite strong, many adolescents often feel that death, drug addiction, and pregnancy could never happen to them (Muuss, 1982). Similarly, they may also have the conviction that they could never contract HIV or AIDS.

AIDS Related Behavior

AIDS, a condition in which the body's immune system breaks down, is caused by the human immunodeficiency virus (HIV). According to the Centers for Disease Control (CDC), as of June 1994, there were 401,749 cases of AIDS and an estimated one million cases of HIV in the United States. Of those who have AIDS, 75,245 are between the ages of 20 and 29.

The CDC states that an individual may be healthy for as long as eight to eleven years from the time of infection. This means someone can have the virus for a lengthy period of time without anyone, including the infected person, knowing it. Since these individuals virtually remain symptom free, it can be assumed that many of the 75,245 AIDS victims in their twenties were likely to have been infected when they were teenagers. Therefore, the critical issue for adolescents has to do with the incubation period, or the time involved before any symptoms of the virus appear.

The CDC (1989) also reported that among teenagers a sexually transmitted disease is acquired every thirteen seconds and a pregnancy occurs every thirty seconds. These teenagers, who are engaged in risk-taking sexual behaviors, can also develop HIV and eventually AIDS. If already infected but asymptomatic, they can infect their partners.

These statistics demonstrate that many youths who are in need of changing their behaviors, whether through abstinence or the use of contraceptives, are not doing so. This is in spite of the fact that AIDS education and knowledge have increased over the past decade (Roscoe & Kruger, 1990). However, despite greater awareness of the AIDS epidemic, only a small percentage of youth has actually changed their behaviors due to fear of infection. Tashakkori and Cleaveland (1989) found that 46% of sexually active college students did not take safer sex precautions after displaying a high level of AIDS awareness. Another study found that 93% of Minnesota high school seniors are aware that having sex without a condom can lead to the transmission of AIDS. However, 39% of these seniors rarely or never use a condom when having sex (Minnesota Department of Education, 1989). In a related study, 61 % of adolescents surveyed believed they were not the kind of person to get AIDS (DiClemente, Zorn, & Temoshok, 1986). Consequently, "adolescents' perceived threat of themselves getting AIDS is independent of their general knowledge about AIDS" (Rotheram-Borus & Koopman, 1991a, p. 33).

This leads to the relationship between the personal fable and AIDS acquisition. A review of the literature presents a link between AIDS and adolescent risk taking behavior (Center for Population Options, 1990; Friemuth, Edgar, & Hammond, 1987; Gardner & Herman, 1990; Jurich, Adams, & Schulenberg, 1992; Lasorsa & Shoemaker, 1988; Millstein, 1990; Rotheram-Borus & Koopman, 1991a, 1991b; Sunenblick, 1988). However, there are no empirical studies that directly connect AIDS with the personal fable. There has been, however, significant research that supports the relationship between certain reckless behaviors, such as unprotected sex, and egocentrism. Past research has shown that the personal fable may contribute to the lack of condom use (Arnett, 1989;Burger & Burns, 1988; Cvetkovich, Grote, Bjorseth, & Sarkissian, 1975; Gershenson & Handler, 1985) despite adolescents' increasing knowledge of the value of contraception in the prevention of sexually transmitted diseases (Association for the Advancement of Health Education, 1988; Sunenblick, 1988). In a one year study by Kegeles, Adler, and Irwin (1988), adolescents were found to be more aware that the use of condoms can prevent sexually transmitted diseases. However, the same group's condom use decreased.

There are also indications that adolescents avoid contraceptives because of limited cognitive abilities (Cvetkovich et al., 1975; Morrison, 1985; Phipps-Yonas, 1980). It is suggested that they are not analytically equipped to comprehend significant health consequences. Furthermore, Burger and Burns (1988) concluded that sexually active college females perceived themselves as both unique and invulnerable and considered themselves less likely to become pregnant when compared to other college females.

Arnett (1989) found that a greater number of adolescents, who had participated in certain high risk behaviors (driving while intoxicated and sex without contraception), underestimated their risk as compared to those who did not engage in these behaviors. In this case, the personal fable leads adolescents to miscalculate each risk so that it appears to be an advantage.

Gershenson & Handler (1985) found the presence of the personal fable in the behaviors of teenage girls who become pregnant. The girls are able to describe their limited futures as a result of their pregnancies. However, they also maintain while their friends can be pressured to have intercourse they, themselves, are able to resist.

Cvetkovich et al. (1975) conducted many interviews regarding teenage pregnancy and the use of contraceptives. Their findings suggest that many adolescents, both male and female, possess a personal fable of sterility. This belief occurs after one or more experiences of sexual intercourse that do not result in pregnancy. Other studies show that female adolescents with higher "cognitive egocentrism" are less effective when it comes to contraceptive decision-making (Green, Johnson, & Kaplan, 1992; Johnson & Green, 1993).

A belief in invulnerability to pregnancy is a key factor in consenting to sex without contraception (Pete & DeSantis, 1990). In a review of a dozen studies on adolescents' use of contraceptives, Morrison (1985) concludes that "at least a third, and frequently more than half of sexually active adolescents cite versions of 'I thought I (or my partner) couldn't get pregnant' as a reason they did not use contraception" (p. 553).

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The lack of condom use is an indication that adolescents may lack the ability to conceptually think about future consequences as a result of present behaviors (Chilman, 1983; Rotheram-Borus & Koopman, 1991a). Such consequences are HIV and AIDS. Given the eight to eleven year incubation period of AIDS, most adolescents do not know any peers with the disease and therefore may subscribe to the personal fable that "they won't get AIDS." They take their future for granted and "believe that the absence of any symptoms today signifies a permanently healthy tomorrow" (Keeling, 1987, p. 28).

Implications

One must recognize that adolescents who experience egocentrism are acting according to their typical developmental level. However, there are certain ways in which counselors, teachers, parents, and other adults can assist young people through this challenging stage. Elkind (1978) advises the following: (1) encourage adolescents to test their assumptions against reality, (2) respond to adolescents in a rational way, and (3) do not over-involve your own emotions. One of the most counterproductive approaches is to argue with someone who is experiencing his or her own version of "reality."

For teenagers, a fundamental source of conflict is the uncertainty and instability of their self-concept. Egocentrism is a developmental way in which a teen attempts to attain a sense of strength. Adolescents need to experience adults and peers who are sensitive and empathic to their concerns and anxieties.

Teenagers need structure that includes practical, clear information and effective guidance. They need opportunities to share their anxieties, experiences, and questions. It is important that adults be clear and concrete and provide natural, logical, and consistent consequences for misbehavior. Open discussion, which includes the use of "I messages" and reflective listening, can help adolescents make healthy decisions about sex and drugs.

Preventive education is significant, especially when dealing with the issue of sexual activity. Sex education and other primary prevention programs need to be broadened to emphasize abstinence, provide for contraceptives, and involve parents, schools, and the community. Such programs must be comprehensive, focusing on the psychological and developmental factors associated with risk taking behaviors (DiClemente, (1990). Since the tragic results of infection are not immediately apparent and adolescents do not focus on the long-term possibilities, potential consequences of sexual irresponsibility must be emphasized. Every adolescent needs to be informed of what can realistically happen and what the future could hold.

Egocentrism is an inevitable developmental occurrence that does, unfortunately, lead to high risk behaviors among adolescents. Experimenting with intravenous drugs and unprotected sex are two major behaviors that can lead to the HIV infection. These high risk behaviors may deny adolescents their future.

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“*Hope is a risk that must be run.*”

–Georges Bernanos, *Last Essays*

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Social Constructionist Counseling with Families When a Child Has Been Raped

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Commonly held stereotypes about rape create a climate of hostility, animosity, and suspicion toward persons who have been raped; this attitude extends to the courts and even the therapy office. The victim is often ignored, and the focus is placed instead on the rapist or on the setting in which the incident occurred. This results in frustration, fear, guilt, or feelings of helplessness and hopelessness on the part of the rape victim. The present article utilizes a Social Constructionist therapy approach, first to examine the client's individual and family meaning system with regard to family myths, attitudes and biases surrounding the rape and then to challenge or to deconstruct this meaning system while planting seeds for the introduction of a new competing system.

The traditional approach to rape typically ignored the victim (Burgess & Holmstrom, 1974), focusing, instead upon the rapist or upon the settings in which rape occurs. Presently, primarily due to the advent of the feminist movement, attention has shifted to the raped person's reactions and life adjustments.

According to recent sexual victimization surveys, approximately 3.67% (George & Winfield-Laird,1986) to 24% (Russel,1984) of women have been sexually assaulted at some time in their lives. Approximately 44% (Russel,1984) of women are estimated to have been victims of attempted assault. Sexual victimization may be an even greater problem for women who seek psychological help. In their study, George and Winfield-Laird (1986) found that 27.78% of male and female patients in psychiatric hospitals had been sexually assaulted, in contrast with a rate of 2.54% for non-patients.

One may surmise that sexual victimization is common among women, and it can result in seriously detrimental psychological effects (Carmen, Ricker & Mills,1984; Cohen & Roth,1987; Kilpatrick, Veronen & Best,1985; Koss,1985; McCann, Sakheim & Abrahamson,1988). In fact, the mental health effects of the victimization of women comprise one of five priority research areas identified by the National Institute of Mental Health (Frazier & Cohen,1992). Persons who have been raped often suffer not only from the direct physical and emotional consequences of the victimizing event (McCann, Sakheim & Abrahamson,1988), but they also suffer from the disapproving responses of others (Hall & Wellman, 1985; Davis & Brickman,1991).

This article focuses upon the attitudes and the biases that rape victims experience, and explores these attitudes and biases in relation to one case study. Also, it intends to demonstrate the application of the Social Constructionist approach to counseling in working with a family when a member has been raped.

Victim Blaming

People often blame rape victims for their fate. This phenomenon has been observed among college students in the laboratory (Acock & Ireland,1983), among persons in the helping professions (Damrosch, 1985), and among victims themselves (Damrosch,1985). It is true of both men and women (Acock & Ireland,1983) and does not discriminate between different cultures (Kanefar, Pinto, & Mazumdar,1985).

Therefore, not only do others blame the victims, but it is also well documented that the victims blame themselves (Lerner & Miller,1978; Miller & Porter,1983). Wortman & Lehman (1985) and Coates, Wortman, & Abbey (1979) have argued that those close to victims may feel threatened by the victim's affliction. They may be uncertain about how they ought to react to victims because they have little experience to guide them, or they do not understand what is or is not appropriate to say or do. As a result, it is argued that others may respond in ways that further hurt the victim. Such behavior can include withdrawal, criticism, ineffective help, excessive help, or inappropriate help (Rock & Pietromonaco, 1987), often adding to the victim's distress.

Women are less accepting of rape myths and are more sympathetic to rape victims than men (Burt,1980; Burt & Albin, 1981; Costin & Schwartz, 1987). Reasons for this may be that women have identified more with the rape victims, and that they are more likely to have experienced sexual assault, and/or are acquainted with a survivor.

Another factor that affects victim blaming is the socially constructed belief systems of men and women. It has been argued (Kleinke & Meyer, 1990), that men who possess a strong belief in a "just world" (moral goodness or egalitarianism) are more negatively judgmental of rape victims than are men who have a weak belief in a "just world." This became evident during an evaluation of a videotaped rape victim. On the other hand, women with strong belief in a "just world" are less negative toward the rape victim than women possessing a weak belief in a "just world." People with a weak belief in a "just world" recommend significantly longer prison sentences for the rapist (Kleinke & Meyer,1990).

Victims suffer not only from the direct physical and emotional consequences of the victimizing event, but they also suffer from the disapproving response of others (Coates, Wortman, & Abbey,1979). Motivational explanations, such as the need to believe in a "just world" and a controllable world (Lerner & Miller, 1978), provide important insights into the reasons regarding why victims are blamed.

Counselors' Attitudes

Most assault victims who seek counseling are seen by professionals unfamiliar with the research findings on the incidence and the effects of rape. Several studies have demonstrated that most practicing clinical psychologists do not read or base their work on psychotherapy research (Cohen, Sargent, & Sechrest, 1986; Morrow-Bradley & Elliott, 1986). This lack of awareness of the research literature on treatment of sexual assault victims may be particularly problematic.

Dye and Roth (1990) have investigated the issue regarding how counselors' attitudes toward sexual assault victims predict their approaches to the treatment of clients. The results of their study indicate that counselors who hold negative attitudes toward victims are more likely to endorse victim-blaming themes and therapeutic treatments which blame victims for sexual assault. Davis and Brickman (1991) feel that the strong detrimental effects of non-supportive behavior should be of particular concern to those who work with rape victims.

Reactions: Significant Others

While the obviously traumatized person is the one who has been raped, the silent, and often ignored, hurting ones are the other family members. Rape is a traumatic event in the raped person's life, but it is also an assault on the family system (Feinauer, 1982). Fathers and brothers of the victim may identify simultaneously with the aggressor and the victim. At times, victims are discouraged from disclosing the rape in order to protect other family members from being traumatized. This is especially true with respect to protecting children. As a result, the rape becomes a secret among those who know about the incident (Mio & Foster, 1991); this, in turn, fosters pathology.

METHODS OF INTERVENTION

Individual Counseling vs. Family Counseling

Traditionally, the problems associated with a rape victim have focused upon the individual traumatic reactions of the person assaulted. The individual has been the unit of analysis. As a result, relevant clinical theories are likely to emphasize internal events, psychic organization, and intrapsychic conflict (Goldenberg & Goldenberg 1991). Methodology in such a situation tends to be retrospective; explanations tend to have a historical basis and to seek out root causes from the past. In this context, individual counseling attempts to answer the question of why something occurred.

Some traditional models of counseling, especially the psychoanalytic, are inappropriate and can be harmful when working with abuse survivors (Brickman, 1984). In most cases, clinicians treating survivors of rape trauma generally use a model borrowed from Transactional Analysis, that encourages the client to parent the wound within (Courtois, 1988). This can lead to a rapid reduction of the person's sense of isolation. Gestalt techniques, guided imagery and hypnosis can be used to uncover memories and to explore and to ventilate feelings, leading to a change in the victim's perspective of the abuse (Courtois,1988).

Family therapists, such as Mio and Foster (1991), point out that family counseling literature generally does not include the entire family in discussing post-rape treatment. Mio and Foster (1991), speculate that this neglect is due to the unwitting belief in old rape myths, on the part of the authors of this earlier literature. Traditionally, family counselors have made a distinction between the marital subsystem and the parental subsystem (Minuchin, 1974). One topic, typically reserved for the marital subsystem, has been sex. Mio and Foster (1991) contend that if writers on rape implicitly consider rape as a sexual act (as opposed to a violent assault), then children will naturally be excluded from the healing process.

A more inclusive approach to family therapy can, without negating the significance of individual internal process and behavior, provide a broader view of human problems. This broader view focuses upon the context in which individual behavior occurs, as well as upon the interpersonal relationships of which the individual is only a part. Rather than attempting to discover the single answer as to why something has occurred, such family therapy stresses reciprocal causality (Goldenberg & Goldenberg,1991).

By adopting such a systematic perspective, family therapy broadens psychology's traditional emphasis on the individual to include the nature and the role of individuals in primary relationship networks such as the family (Liddle, 1987). From this perspective, an individual who manifests dysfunctional behavior is seen as a representative of a system that is faulty. This system recognizes that the cause and the nature of that person's problems may not be clear from a study of his/her past alone, but may be better understood when viewed in the context of an ongoing family relationship system that is in disequilibrium (Goldenberg & Goldenberg, 1991).

In this sense, family therapy represents a new way of understanding human problems, of understanding behavior, of the development of symptoms, and of the resolution. Beyond a concern with the individual's personality, characteristics or repetitive behavior patterns (Goldenberg & Goldenberg, 1991), beyond a concern with that which transpires between people (where individuals remain the unit of study), this conceptual change focuses attention upon the family as primary subject matter.

Social Constructionist Therapy

Social constructionist concepts applied to family therapy provide another significant approach to treatment. Constructionism dates back to philosophers such as George Kelly (1969) and Jean Piaget (1951). These writers have contributed to the belief that knowledge regarding the world is constructed by the observer. Reality is seen experientially in terms of how one subjectively interprets the constructions received. Therefore, one's story of the world and of how the world works is not the whole world; one's experience of the world is limited to an internal description of it.

Social Constructionist theory, developed by Berger and Luckmann (1966), and more recently by Gergen (1985), offers a theoretical context within which the family can be included.

This context involves a broadened concept of the family including a much wider range of interacting human systems. According to Boscolo and Bertrando (1993), counselors should consider more than just the family system that seeks help; instead, they should begin hypothesizing about the broader significant system attached to the problem: the system of relationships that unites the people who have brought the problem for treatment.

This approach considers members of the nuclear family, of the extended family, the patient's friends and peers, the school or work settings, and, most importantly, the helpers and the health and the social services the patient may have had contact with over time. Thus, the emphasis in therapy shifts from the behavior of the observed system to the behavior, the ideas, the theories and the personal assumptions of the observing system (Boscolo & Bertrando, 1993).

Social constructionist theory places an emphasis upon the social interpretation and upon the intersubjective influences of language, of family, and of culture. Gergen (1985) states that, from the constructional position, the process of understanding is not automatically driven by the forces of nature but is the result of an active, cooperative enterprise of persons in relationship. As a result, social constructionist theory proposes that there is an evolving set of meanings that continually emerge from social interactions. These meanings are part of a general flow of constantly changing narratives (Atwood & Ruiz, 1993). From these socially constructed meanings, flow psychological meanings and scripts for behavior. Persons develop an individual identity, an individual script, accompanied by individual meanings which are created by, and embedded in the dominant culture. Using this as a backdrop for therapy, it is useful to explore what being raped means for each family member and, possibly, for other members of the supporting system.

Social constructionist therapy, as has been described by Atwood and Dershowitz (1992), explores the family meanings that incidents, behaviors, and encounters with persons who have been raped have for these victims and their families. It also describes how these meanings are determined by the socio-cultural environment. The socio-cultural environment equips rape victims with methods and ways of understanding and making judgements about aspects of rape, ranging from how they feel about themselves to religious values (Atwood & Dershowitz, 1992).

Using the above as a background for treating families with a member who has been raped, the six stage therapeutic model as has been proposed by Atwood and Dershowitz (1992) is presented: (1) Joining the Family Meaning System, (2) Proposing the Notion of a Socially Constructed Family Meaning System, (3) Learning the Family Meaning System, (4) Challenging the Family Meaning System, (5) Amplifying a New Meaning System, and (6) Stabilizing the New Meaning System. These stages are illustrated through the use of case material.

APPLICATION OF THE SOCIAL CONSTRUCTIONIST THERAPY

The following case illustrates the use of the social constructionist therapy approach when working with a family including a member who is raped. Lorna Williamson (fictitious name) is a well-developed, mature looking fifteen year old girl from a middle class family. She is the third child of a family of six. Lorna is considered to be energetic and outgoing, having many friends. She has a good sense of humor and does average to above average school work. Her parents have many close family friends whose children are of Lorna's age. The parents and their friends share many of the responsibilities of child care, and their homes are open and accessible to each other.

One morning, the father of one of Lorna's friends had visited her home, while her parents had been away. The visitor had started touching Lorna in a way that had made her uncomfortable. After a short while, Lorna had been raped. As a result, she had felt guilty, shameful, remorseful, confused and dirty. Before he had left, Lorna's attacker had told her that he was sorry for what had happened and begged her not to tell. In addition, he had threatened her, reminding her of his past kindness. Lorna had pondered what to do. Should she tell, and if so, whom? She had decided to keep her story to herself.

The perpetrator of the crime still comes to Lorna's house for family get-togethers, pretending that nothing has happened. This makes Lorna all the more uncomfortable, and she begins acting out. Several months pass after the incident and Lorna succeeds in keeping her secret. Then he rapes her again. This time he is more aggressive and demanding. She feels completely violated and abused. The pain, shame and guilt were more intense. She decides that she will not keep her secret hidden any longer. Lorna tells her best friend, who discloses it to another friend; like a wild fire, the news soon spreads. With mixed feelings of shock and anger, Lorna's parents hear of the incident from family friends. They blame Lorna for not coming to them.

Lorna and her family are subsequently referred for counseling. When she comes in, Lorna appears confused, depressed, embarrassed, nervous and hurt. She cries most of the time, reporting feelings of sadness and rage.

The Family Meaning System : Joining and Accommodating Its Style.

Establishing a rapport with the clients is one of the most critical therapeutic tasks (Weeks & Hof, 1987). Therefore, at the initial stage of therapy with Lorna and her family, there is the need for the counselor to blend into the family and to begin understanding the family themes and family myths. The counselor must sense any member's pain at being excluded, blamed or scapegoated. To distinguish which persons share pathways of open communication and which do not, the counselor intuitively obtains a picture of the family structure in operation (Goldenberg & Goldenberg, 1991). Once this is done, the counselor joins the family's emotional experience. Joining them allows the family, and especially the victim, to know that the counselor understands and is working with and for them.

Some families eagerly await the opportunity to discuss their problems with someone, and for these families, the joining process tends not to be a serious problem. However, for most families such as Lorna's, joining the family meaning system is a major hurdle that must be overcome if counseling is to be helpful. Many families of rape victims have developed a deep distrust of new people, especially of those who may be probing into thoughts and into feelings which the families have worked hard to repress and deny (Weeks & Hof, 1987).

When Lorna Williamson's family had come in for therapy, they had showed great reservation in discussing the incident. They had spoken about their "privateness" as a family, and they had expressed concern regarding the impact which such therapy might have. They also had reported that Lorna was having difficulty with her school work, in addition to acting up at home, at school and at church. There had been times, they had said, when she had been depressed and silent for long periods. The father, particularly, had had a difficult time coping. He had felt guilty that he had not protected his child.

Developing the Notion of a Socially Constructed Meaning System

The first step in developing a treatment plan is to obtain an indepth individual and relationship history using the same general approach as would be used in other cases of marital and/or sexual dysfunction. Martin (1976) and Bowen (1978) believe that multigenerational patterns and influences are crucial determinants of nuclear family functioning. Hence, a family genogram, worked out with the family, provides a useful tool in allowing counselor and family members alike to examine the family's story, and in examining the ebb and flow of the family's emotional process in the intergenerational context.

This approach gives the counselor an opportunity to explore any past sexual traumas that family members might have encountered, the family's mechanism for coping with these traumas, and the intervention strategies that had been used. It also helps the counselor to become aware of any hidden fears, attitudes or biases on the part of the immediate family members as they retell their story. The genogram may also suggest special emotional patterns in each partner's family of origin, thus providing data for assessing each spouse's degree of fusion to extended families and to one another (Goldenberg & Goldenberg, 1991).

Family patterns tend to repeat themselves (Atwood & Dershowitz, 1992). What happens in one generation will often occur in the next, as the same unresolved emotional issues are replayed. Therefore, exploring the family's past can be a useful first step for the counselor in restoring the present and opening up new possibilities for the future. In many cases, this process brings forth for the client new awareness of competencies and strengths (Atwood & Dershowitz, 1992).

Thus, the family members may be asked questions associated with painful sexual traumas. These questions may include: "Was anyone in your family sexually molested before?" "How did that make you feel?" "Did anyone make you do anything sexual that you did not want to do?" "What are your fears about rape?" "Do you remember what sex meant to you when you were small?" "Who gave you those meanings?" When the resulting evaluation interview data is put into schematic form in a family genogram, both counselor and family together are better able to comprehend the underlying emotional processes connecting generations (Goldenberg & Goldenberg, 1991).

In this case, it had been evident that Lorna's father had berated himself for not having protected his daughter. Because of the early departure of his own father from his family of origin and the ensuing struggles his mother had had with her children, Lorna's father had vowed not to leave his family and to always protect them and to provide for them. Now, he had felt like a failure, for he had not been able to protect his daughter. In addition, he had been experiencing anger and hostility toward the perpetrator, and had wanted to confront him.

The mother's story is somewhat different. She had felt guilty and simply stupid for not having picked up any clues in the past. She had also experienced anger and disappointment, having felt betrayed by one of her best friends. She had also expressed other concerns about telling the story to the family and the circle of friends.

Lorna's emotional story is the most complex. First, she had felt deeply ashamed and embarrassed. She had been aware that some people had already blamed her for that which had happened, thus causing her to feel more guilty. In addition, she had been experiencing problems with her parents because they were disappointed that she had not first come to them. Lorna's concern had been that she had not thought they would believe her. She had been trying to tell them indirectly, through her acting out but had felt that they would not have listened.

Learning About The Family Meaning System: Attitudes and Biases

At this point in the counseling, Lorna's family had begun to state their view of rape and to reflect upon the implications of the crime. Here the counselor's role is to listen carefully to what is in the background, as well as up front, and to pay attention to the family's linguistic signals through metaphors, legends, traditions, myths and through folklore.

In learning the family's meaning system, the counselor identifies what message the family members select from the world around them to fit into each aspect of their meaning system, and determines how the message reinforces the existing structure. It is at this point that each family member becomes aware of how he/she is participating in the perpetuation of society's myth regarding rape.

When Lorna had been asked the question, "Do you blame yourself for allowing it to happen?" her first response had been, "Yes." She further explained that "she had been at fault because she should have known better."

When Mr. Williamson had been asked the same question, his response had been similar. He had blamed himself for not having been there for Lorna. He had been shocked to learn that there had been those who had felt that Lorna had caused the rape to happen. Mrs. Williamson's response had been to blame herself for making her home so free for others to come and go as they had chosen. She had expressed guilt about some of the criticisms concerning Lorna and had felt betrayed by her daughter for not having first come to her with the story.

Exploring these attitudes and biases about rape victims within the family will help the counselor frame a social construct. Understanding this construct may help develop appropriate questions, such as: "How do you feel about people who have been raped?" "What does it mean to be raped?" "What does it mean to have a close family member raped?" "Do you think that women fantasize about rape?" "What are some of the things you hear your friends say about people who have been raped?" "What are your relatives saying?" "How is this incident affecting you psychologically, socially, spiritually, and emotionally?"

The Family Meaning System : "The Challenge"

The Williamsons found it difficult to share the story with other family members, and face the shame they had felt about other people's reactions. This is common. Family members may often feel inadequate and unable to deal with the victim's intense feelings (Silverman, 1978). Some family members may feel resentment and anger toward the victim for frightening and humiliating them. Some people avoid the victim and the victim's family in order to avoid the victim and her family's feelings of helplessness. Some people may have misunderstandings or prejudices, or may accept myths surrounding the crime of rape which create internal conflicts for themselves (Feinauer & Hippolite, 1987).

Once it is accepted that myths, attitudes and biases toward persons who have been raped are socially constructed as part of the family meaning system, it then becomes possible to deconstruct them and to introduce a competing meaning system. Here, the role of the counselor is to identify competing constructions or exceptions in the family's meaning system (Atwood & Ruiz, 1993), to break up old frameworks, and to establish a new foundation for growth and development.

It is essential to move at the client's pace. For example, the rape victim will not move beyond the traumatic experience until she is able to regain a sense of control over her world. She must again believe that she is able to make choices. The counselor should challenge the client to take charge of her life and not abdicate the ability to alter the future. The victim must know that sadness and anger are appropriate. The victim must recognize that only after she has grieved and has learned to acknowledge and handle feelings of anger, aggression, hostility and rage can there be movement toward resolution and toward regaining a sense of freedom.

Family members who use denial or who encourage the victim to keep the rape a secret and who do not allow other family members an opportunity to discuss their feelings or fears, can be assisted in understanding that the rape is an experience that the victim must overcome and that concealment is destructive to the family relationships (Feinauer, 1982). Keeping rape a secret may serve to block adaptive coping strategies, causing maladaptive strategies to be employed (Mio & Foster, 1991). Family members can be helped to understand that if this occurs any sense of safety and trust that has been established in the family will be destroyed, and that all relationships will be seen as conditional.

The counselor can challenge the family to understand any attempt to hide from the truth, or to distract the victim from the crisis may deprive her of the opportunity to mourn the personal loss inherent in the rape experience (Feinauer, 1982). Rather than denying the reality of what has happened, the counselor can assist in deconstructing the victim's thoughts and in regressing the family to a time when the rape had not occurred in order to reevaluate their lives before the event. The counselor can then reconstruct the family's concepts for the future. This may be done by providing positive alternatives and hopes for a new beginning.

Lorna's family had been encouraged to focus upon the positive elements of their caregiving. They had been encouraged to observe when they had been happy and to increase those behaviors. The counselor can highlight and emphasize the smallest positive change by obtaining thorough descriptions of developments and possible solutions (Atwood & Ruiz, 1993).

As the counselor had continued to challenge the family members' meaning system, Lorna's mother had seen the need to include her own mother and the other children in the counseling sessions. She had become less concerned about the feelings of others, and had started focusing more upon her own feelings, the feelings of her family, and especially the feelings of Lorna. Her own childhood molestation had been taken out of the background and had been placed in the foreground. It had been dealt with for the first time with her own mother. Lorna's father had refocused his attention on his daughter and had assured her of his constant love and acceptance. He had wanted more family time with her, and they have now launched a new, dynamic relationship.

Lorna had come to accept herself, reducing her self blame. She had begun to look beyond the criticism of her peers. She had refocused on her priorities in life and, instead of trying to please her peers, she had started looking at life from her own perspective, accepting the possibilities of a new tomorrow. When the counselor had asked her if the family could think of a time in the future when the problem would not be there, and what life would be like, they all had expressed optimism.

Family's New Meaning System: Amplification

Therapy based on Bowen's (1978) theory (no matter what the nature of the presenting clinical problem) is always governed by two basic goals. The first of these goals is reduction of anxiety and relief from symptoms. While therapy could not have erased the rape, Lorna had been able to feel less anxious, and to process the anger, the embarrassment, the guilt, the shame and the victimization that she had experienced. She had continued to attend school and to perform at the same level as before the incident. The second goal is an increase in each participant's level of differentiation in order to improve adaptiveness (Kerr & Bowen, 1988). Lorna had been helped to face the family, to integrate her feelings and to relate in a way that had enabled her to feel comfortable, with each member accepting her story and giving positive support and empathy. She had also been helped in coping with any form of rejection or blame that she had received from the extended family.

To improve adaptiveness, the new construction in the family meaning system had to be amplified and elaborated, providing a foundation for the use of the new construct in order to devise new solutions (Bateson, 1972). This had allowed the Williamson family to focus upon the future rather than upon the past and, in addition, helped them to create a new level of intimacy within the family.

It is the counselor's task to amplify the socially constructed competing events in the family's meaning system by asking such questions as: "What would life be like without the problem?" "What changes would there be in the family if this problem were to go away now?" "What would be different?" "How would it be different?" By helping the family to deepen the experience of the relationship when the rape issue is absent, the counselor facilitates a new construction of a more positive relationship (Atwood & Dershowitz, 1992). This new construction holds new meanings and, thus, new possibilities for the family.

Through the amplification engendered by the counselors questions, Lorna's father had seen what life would have been like without the problem, which had strengthened his anticipation of the family's renewed relationship. In this context, he had spoken of his desire to accept the challenges of society and to move on in life with his family's new meaning. He had seen beyond the skepticism of others to a brighter future. Lorna and her mother had also described their hopes and goals. They had identified feelings of relief, as they had been able to talk about difficult issues and to confront each other. The Williamson family had been able to create a more positive outlook for the future.

The Family's New Meaning System: Stabilization

Having amplified their meaning system, this family had resolved that counseling had been completed. However, counselors should be aware that in many instances families have difficulty reintegrating their sense of control, esteem and hope for the future. They may believe that they can talk more openly, but emotionally they may still be floundering. According to Atwood and Ruiz (1993), by asking questions related to future trends and choices, the counselor makes that future more real and more stable. These questions may include: "How do you see your future without the problem, as compared to your future with the problem?" "How do you see yourself relating to friends in the future without the problem?" "Do you see yourself, at church, becoming involved again without any thought of the problem?"

Another way of stabilizing the new meaning system is put forth by Feinauer and Hippolite (1987) in their description of symbolic rituals. They contend that a safe symbolic ritual may be a desirable way to provide each individual member, and the family as a whole, with an opportunity to experience, reexperience, and re-decide how they will respond to the traumatic event through an open expression of their emotions and of their responses. Re-integration of their responses and reactions to their shared life crisis may enable them to respond to one another in ways previously not open to them.

Through these rituals family members can recount their story; they can tell how and when they had first become aware of their problem and what intervention steps had been taken. They can look back at their moments of transition and can review the solutions they had utilized for the problem. The counselor can enter this arena of story telling, with a possible inclusion of his/her version of the victim's counseling adventure. Both counselor and counselee can then discuss their collaborative efforts, thereby helping to strengthen the family's new meaning system.

Lorna had craved acceptance and support from her friends, and she had felt empowered to face the biases and attitudes of those of her peers who were negative toward her. Now that she had seen school as an opportunity and as a chance to redeem herself, she had expressed confidence that her academic work would improve. She had anticipated a new and more meaningful experience with her parents and had felt that with this understanding and this trust, her relationship, on all levels, would be strengthened.

Her mother had felt comfortable discussing the incident with other family members and had looked forward to the time when she would discuss it with selected friends in her church. She had accepted the situation and was ready to go on with her life and with that of her family. Lorna's dad still had his feelings of anger. It had taken him much longer to allow these feelings to go; he had needed more time.

Summary

Rape victims suffer not only from the direct physical and emotional consequences of the event, but also from the skeptical or disapproving response of others. Readiness to endorse certain "rape myths," stereotypic beliefs about the victims, the attackers, and the circumstances of rape, is one of the most powerful factors affecting social and, to some extent, legal evaluations of rape victims and of their claims.

The case presented illustrates the experience of a teenager who was raped and, through the use of social constructionist therapy, was able to deconstruct and reconstruct her own and her family's meaning system. Modifications in the narratives the family related about their meaning systems led to opportunities for change and progress.

All the above is illustrative of the six-stage therapeutic model described by Atwood and Dershowitz (1992) based on the theory developed by Gergen (1985). As stated earlier, these stages are: (1) The Family Meaning System: Joining and Accommodating Its Style. (2) Developing the Notion of a Socially Constructed Meaning System. (3) Learning about the Family Meaning System: Attitudes and Biases. (4) The Family Meaning System: "The Challenge."

(5) Family's New Meaning System: Amplification. (6) The Family's New Meaning System: Stabilization.

This suggested approach is not intended to be exhaustive, nor is it intended to replace other methods of intervention; rather, it seeks to provide a new and challenging method of altering the family structure through working with the family meaning system. The development is not seen as fixed or linear. As the family grows and progresses, changes will come naturally. The family members will adjust gradually to these changes as they go through the realities of their life cycle.

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“ *To do just the opposite*
is a form of imitation. ”

–GEORG CHRISTOPH LICHTENBERG, *APHORISMS*

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Childhood Chronic Illness and Families: A Review of the Literature and Implications for Counselors

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Parents of children with chronic health conditions face a demanding and often lonely ordeal. The enormous stress generated by the need for long-term attention directed toward medical concerns is both arduous and frustrating. Providing care for the ill child while balancing responsibilities for other family members is a difficult task, often augmented by the demands of increased financial responsibilities. In addition, parents often experience a lingering chronic sorrow that is heightened as the child reaches different developmental stages, making coping and adjustment a difficult task. This article discusses the literature pertaining to the family response to chronic illness and describes implications for counselors to help them to assist parents in making these adjustments. Counselors can provide both a therapeutic environment and the resources to alleviate stress.

Coping with chronic illness and disability is understandably a complex issue for individuals and for families. In addition to the required long-term attention toward medical concerns, individuals must face the enormous psychological challenges implicit in any disabling condition. Chronic illness impacts families on many fronts: socially, behaviorally, and financially (Sabbeth, 1984). For parents with ill children, these problems can become overwhelming in an already troublesome child-raising society. Clearly, chronic illness is an arduous and demanding experience for both the child encountering it and for his or her family.

Approximately 10-15% of children experience some type of chronic illness and disability with an additional 10% (1-2% of the total population) termed severe (Hobbs, Perrin, & Ireys, 1985). Childhood chronic health conditions include disorders such as chronic kidney disease, cystic fibrosis, leukemia, and congenital heart disease. All are costly to treat and require extended care (Hobbs et al., 1985). Increasing medical and technological advances have resulted in more children surviving what were once life-threatening diseases (Newacheck & Taylor, 1992). In addition, longer survival rates for many chronic conditions have created new challenges as parents cope with developmental issues related to adolescence and to transition into work and independence (Blum, 1992).

Due to limited knowledge and experience in dealing with chronic childhood illnesses, counselors are often ill-equipped to aid families in meeting the intricate and unique challenges confronting them. The purpose of this article, therefore, is to discuss significant psychosocial issues impacting parents of children suffering from a chronic illness and from a disability and to discuss the role that counselors can take in assisting families in successful adaptation.

The Experience of Chronic Illness

While numerous studies have attempted to identify specific sources of stress related to childhood illness, much of the literature is inconclusive or conflicting (Turner-Henson, Holaday, & Swan, 1992). Research has examined family distress due to the daily demands of illness (Goldberg, Morris, Simmons, Fowler & Levison, 1990; Turner-Henson et al., 1992) with particular emphasis on the responsibility and on the caregiving burdens placed on the mother (Anderson & Elfert, 1989; Sabbeth, 1984). Much of the child focus has centered on matters pertaining to adjustment issues related to school attendance (i.e., absenteeism, school achievement), home tutoring, or reentry concerns following diagnosis or hospitalization (Fowler, Johnson, & Atkinson, 1985; Sexson & Madan-Swain, 1993). Research consistently shows that childhood illness places extraordinary demands on the family unit.

While most families do find the internal resilience and the strength to cope (Mullins, 1987; Sinnema, 1992), they are often alone in this process. For parents facing more substantial issues (i.e., fear of death, numerous hospitalizations) related to their child's illness, there may be a sense of isolation at a point when support is critically needed. To best meet the needs of these families, counselors must be well informed regarding the ramifications of childhood chronic health conditions. It is the intimate experience of illness in the family—the on-going, evolving procedure in which children and parents continually adapt and grapple that needs to be recognized if counselors want a true understanding of the disability process. Counselors must sensitize themselves to the experience of parents and of children. Beatrice Wright (1983), a rehabilitation psychologist, describes this as the gaining of the "insider" perspective in which one perceives the event in a similar manner to the one undergoing it. Counselors need to be attuned to problematic periods of stress for both intervention and prevention of maladaptive patterns of adjustment.

Chronic Sorrow

Understanding the impact of chronic illness on families requires an understanding of loss. According to Lindgren, Burke, Hainsworth, and Eakes (1992), the term "chronic sorrow" was originally used in describing the feelings of parents of children who suffer from disabilities. This is in regard to the pain associated with loss and with disappointment. This sorrow is described as a "long-term periodic sadness" as a response to their continual experience of loss. Moreover, this sadness is of a more cyclical and recurrent nature rather than of a time limited grief (Davis, 1987). Consequently, counselors should not expect that the parents of children diagnosed at birth or during the child's early years to have completed the grieving process. Limitations highlighted during later developmental stages may foster a reoccurrence of grief. Parents may experience periodic episodes of sadness as the implications of the illness come to the forefront. These periods of melancholy may wane during the times when the illness takes a secondary role in the daily life patterns of the family (Turner-Henson, et al., 1992). Furthermore, counselors should recognize that these reactions are neither pathological grief nor depression. They are, instead, normal responses to difficult circumstances (Lindgren et al., 1992).

Parents are faced with both worry over the implications of the illness and with the acceptance of loss regarding their own mental picture of a "normal child" (Ziolko, 1991). They are required to assume caregiving tasks for the ill child, often without time or tolerance for mourning (Davis, 1987). Grief may also be intensified by parents' feelings of guilt. Peggy MacGregor (1994) notes that parents of children with mental illness may experience the grief process with an "exaggerated" sense of guilt. This is due to a "heightened sense of responsibility for the well-being" of their child (p. 162). Societal and cultural views of disability related toward perceived cause and responsibility may also foster parental guilt regarding other types of illness and disability as well. Counselors must be cognizant that as sadness often does not subside completely following initial diagnosis, parents may continue to lament the losses their child experiences at differing developmental stages (Wikler et al., 1981). Lindgren et al. (1992, p. 32) note that "... parents of a handicapped child may have other normal children, but their normality will not abolish the pain and suffering the ill child endures, or alter the developmental milestones the ill child is not able to reach." Specific stages of development (i.e., first step, entering school) may intensify parental feelings as they also serve to highlight limitations more clearly (Davis, 1987).

Family Adaptation

The manner in which the family members adapt to the child's illness is crucial. Seaburn, Lorenz, and Kaplan (1992), researchers of chronic illness meanings, suggest that individuals, suffering from chronic illnesses, and their families must give meaning to the illness experience; therefore, cultural and familial socialization contribute to the meaning ascribed to the event. These researchers further note that individual family members may experience and may view the illness differently. Therefore, the meaning established for the family is often an "intertwining" of their perceptions. Consequently, the impact on individual family members is a critical component to the adaptation process that counselors need to identify.

Since the grief process is an individual experience, personality differences of family members, in addition to prior experiences of loss, will have a strong impact upon mourning and adjustment (MacGregor, 1994). Parents are often required to cope with the child's illness and/or disability while attempting to meet the needs of other family members (Clements, Copeland, & Loftus, 1990).

Although research findings are inconclusive, most studies show that siblings are subject to adjustment problems (Gallo & Knafl, 1993; Howe, 1993). Younger siblings appear particularly vulnerable because the complexity of both the nature and the extent of the illness is often beyond their comprehension. In addition, misinformation and/or lack of information about the medical condition may cause the younger child greater confusion about the difficulties faced by the family (Lobato, 1990). Siblings may experience distress due to lack of attention by parents and due to disruptions in daily routines (Ziolko, 1991). Variables such as the nature and the extent of the illness, the age and the gender of the sibling, and the resources available to the family all play a role in shaping the healthy sibling's response to the situation. Parents, therefore, must balance care for the ill child with responsibilities regarding the needs of the siblings and the needs of themselves.

Mary Ellen Ziolko (1991) notes that there are four tasks that parents must accomplish when learning that their infant has a disability. These include dealing with grief, acknowledging their failure in having a "normal" child, resuming their attachment to the child, and developing both understanding and acceptance of the child's differences. All of these internal responses are intense and value-laden. Parents are confronted with their own personal sorrow and with their concern for the limitations that their child does and will experience.

Parental Emotional Stress

The time of initial diagnosis is understandably a stressful period, but parents often endure other significant periods of anxiety. Clements, Copeland and Loftus (1990) describe five critical points: 1) the time of initial impact or diagnosis, 2) periods of increased physical symptoms, 3) support structure changes, 4) parental absences which alter the family unit structure, and 5) developmental changes which, in essence, highlight the differences between their child and those without illness and/or disability. In a study conducted by Lynn Wikler and associates (1981), a group of parents of children suffering from mental retardation reported that their sorrow was periodic. They indicated that the availability of effective professional assistance during these times had a great impact on their daily coping.

An additional stressor may result as parents deal with their own individual grief when a partner's grieving style does not match his or her own style (MacGregor, 1994). Parents may also be required to deal with this stress alone. This is due to the number of single parent families in society today. Counselors can provide a supportive environment and an arena for parents to discuss concerns both individually and jointly. They can help parents understand each other's method of coping in order to better handle misunderstandings that may arise.

As the child reaches school age, additional stressors may impact the family unit. For children whose physical appearance may differ or has been altered by medical treatment, increased anxiety may develop (Sexson & Madan-Swain, 1993) for both the child and the parents. In addition to this, parents who have been the primary caregivers are now required to yield control to teachers (Clements et al., 1990) who often are inexperienced and are less knowledgeable about chronic conditions than the parents themselves (Lynch, Lewis, & Murphy, 1993; Sexson & Madan-Swain, 1993).

Adolescence is a particularly stressful period for all children. As children suffering from chronic conditions reach adolescence, counselors can be of great value to families. This may be achieved by helping the family to sort out illness issues as opposed to developmental issues. Counselors can assist parents in identifying how illness is in fact impacting on the developmental process. Due to medical advances, children are surviving health conditions that were at one time fatal. Robert Blum (1992) notes that some complicated issues will emerge as these young people evolve from dependence to independence in adolescence and in early adulthood. Parents have typically been the primary caregivers up to this point. They may experience anxiety and may worry as they relinquish this role.

As a result, the process of adjustment is long-term. Periods of increased stress are often episodic and are not clearly predictable. In addition, many chronic conditions are of a remitting-relapsing nature with uncertain patterns and prognosis. This continual struggle often exceeds the understanding of those who interact daily with the family. Barbara Hillyer Davis (1987) reports that parents of children with disabilities describe themselves as having entered a community altered by grief. This community segregates between "those who have known inescapable sorrow and those who have not" (p. 357). Counselors can play a pivotal role in helping parents cope with this sense of uncertainty and this lack of control. They can assist parents in understanding that feelings of stress related to chronicity are normal. Furthermore, counselors can provide information concerning specific transitional periods that might be particularly stressful allowing parents to prepare for and to be alert to potential problematic stages.

Caregiving Stress

Caregiving to a chronically ill child is a major parenting responsibility. The impact upon the family caring for an ill child is intensive and far-reaching. In reviewing emerging themes from 60 books written by parents of children with disabilities, June B. Mullins (1987) notes that although many parents report being better people for their "struggle," the actual picture regarding the impact of this responsibility upon the family is very different. Despite the glory of the struggle, the care of a chronically ill child places "extraordinary demands on the physical and financial resources of the family" (p.31).

Although families bear the enormous responsibility of caring for the ill child, limited research has explored parental perspectives concerning this caregiving (Clements, Copeland, & Loftus, 1990). Parents often have limited knowledge about the child's illness. Despite this, they are often required to maintain substantial "vigilance" in order to make complex judgments about symptoms. They are responsible for making crucial decisions concerning immediate need for treatment (Hauenstein, 1990). In addition, Hauenstein (1990) notes that along with the pressure of continued vigilance, parents who misjudge their child's symptoms may also be burdened with guilt. Parents may have significant concerns regarding the future ramifications of the illness for their child. Moreover, they may be apprehensive about the prospect of long-term dependency by the child (Mullins, 1987) and worry about who will assume caregiving responsibilities if they no longer can.

Parental Financial Stress

Families often need to make changes and sacrifices for the ill child. As chronic illness and disability require long-term care, families often find it difficult to afford the high costs involved in outpatient treatment and hospitalizations. This is in addition to routine daily home-care (Hobbs, Perrin, & Ireys, 1985). Also, obtaining and/or maintaining adequate health insurance may be a concern (Marcenko & Smith, 1992). Children with chronic health conditions experience high rates of school absenteeism and sick days (Newacheck & Taylor, 1992). Parents face extraordinary stress related to providing essential accommodations in terms of educational, medical, and environmental needs.

In addition, social support networks for parents with ill children are often minimal (Kazak & Marvin, 1984). The overwhelming caregiving burdens and the belief that others cannot understand their experience frequently limit more normal family social interactions. Parents involved in getting their child to the physician's office or to physical therapy on a regular basis may have little time to socialize with neighbors or with friends. Time constraints, concerns related to health maintenance for the child, and the daily living pressures related to managing a disability in an often architecturally inaccessible environment may hinder opportunities for more intimate adult friendship building.

Conclusion

The demands on parents with children suffering from chronic conditions are immense. Counselors can provide both an understanding environment and assistance in identifying resources to lighten the parenting load. Through their recognition of patterns of grief and sorrow, counselors can reassure parents that their feelings are normal and can provide assistance when their reactions become maladaptive (Ziolko, 1991). Counselors may also be instrumental in helping to reduce stress by giving parents a place to vent pent up emotions and by teaching stress reduction techniques.

Counselors can help empower parents by referring them to parent support groups and to agencies for assistance (Stone, 1989). They can identify programs that provide respite care and that help with caregiving duties. One innovative program described by Valerie Kuehne (1989), the Family Friends program in Omaha, trained older adults to assist families of chronically ill children. By sharing some of the caregiving responsibilities, the Family Friends provided parents with time to devote to their own personal activities. Programs providing respite care exist in many communities. Additional groups such as Parents Helping Parents, a support group for parents of children suffering from chronic illness and from disabilities, are available. Groups such as these provide both information concerning resources and a connection with other parents facing similar problems. Counselors can act as a link between parents and needed supportive resources, offering both emotional and financial supports.

The overall goal of the counseling process should be one of assisting parents in planning for the future needs of the child, helping them understand developmental stages and dealing with issues of dependency and independence. Furthermore, counselors can help parents make the transition through the various stages of loss and adjustment. Parents may often need assurance that their sense of loss is normal and that they are not alone in handling this difficult process. In addition, parents may need to recognize that long-term follow-up with periodic counseling during stressful periods might be appropriate. Counselors should assist parents in developing appropriate coping strategies and in improving communication with others regarding their own needs. Lastly, counselors can provide acceptance and sensitivity to the reality of the illness experience.

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> “*The past is a foreign country:*
> *they do things differently*
> *there.*”
>
> –L.P. Hartley, *The Go-Between*

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Culture and Empowerment: Counseling Services for Immigrant Chinese American Families

George K. Hong

This article examines culture-related factors that put the immigrant Chinese American family at risk of dysfunction. It presents the concept of the cultural gap which pertains to the discrepancies between home and mainstream cultures as well as to the cultural incongruity between parents and children within the family. The issues and solutions are schematically presented in the framework of the Zipper Model *which involves both primary and secondary prevention.*

Asian Americans have often been presented in the mass media as model ethnic minorities (Brand, 1987; McGrath, 1983; Williams, McDonald, Howard, Mittlebach, & Kyle, 1984) who are high achievers both academically and economically. Their success is attributed to cultural factors such as the Confucian emphasis on education, family values and on the work ethic (Brand, 1987; McGrath, 1983; Williams et al., 1984). However, in spite of their cultural heritage, there are many Asian American families which are at high risk of becoming dysfunctional (Hong, 1989; Lee, 1979). Indeed, in recent years, problems in the Asian American communities such as teenage runaways, gangs, and youth crimes, are gaining the attention of the mass media (Chua-Eoan, 1990; Donnelly, 1993; Ingrassia, King, Tizon, Scigliand, & Annin, 1994; Kifner, 1991). While Asian cultural values and practices may be a framework for success, the discrepancies between Asian cultures and mainstream American culture may be a stumbling block for many. The purpose of this article is to familiarize counselors with this issue by conceptualizing these

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culture-related risk factors and by examining possible intervention strategies.

Considering that Asian Americans are a diverse group, having immigrated to the United States from various countries, cultures, and speaking different languages, this article will focus on Chinese Americans, for they are the largest subgroup comprising the Asian American population (U.S. Bureau of the Census, 1991). The term "immigrant families" is used in order to refer to nuclear families having members, typically parents, who are immigrants. Such families represent a vast majority of Chinese Americans. This is because approximately two-thirds of the Chinese American population is estimated to be foreign-born (Lee, 1982; Liu & Fernandez, 1987)

Concept of The Cultural Gap

The concept of the cultural gap is useful in examining the culture-related risk factors facing immigrant Chinese American families. This concept refers to the discrepancies between traditional Chinese culture and mainstream American culture. There are two aspects of this cultural gap. The first pertains to the discrepancies between the home culture and the external mainstream culture. The second pertains to the differences between parents and children who often experience different degrees of assimilation into Chinese culture and mainstream American culture (Hong, 1989). These two aspects of the cultural gap are major risk-factors which threaten the functioning of the immigrant Chinese American family.

Cultural Gap Between Home and External Environment

Among the external mainstream institutions exerting cultural influence over a family, the school plays a particularly powerful role, for it is a setting in which children spend a major portion of their formative years. The cultural gap between school and home is discussed in the educational literature as cultural discontinuity (Gollnick & Chinn, 1990; Ogbu, 1982). It concerns the lack of affirmation of ethnic minority cultures in the school setting. For example, are minority cultural values, norms, and practices being respected by the school? Is one's culture or ethnic group being presented properly, if at all, in the school's curriculum?

One easily observable example of the cultural gap between the Chinese American home and the school is the use of language. How the school treats children's home language has a strong impact on their self-esteem and identity (Gollnick & Chinn, 1990). Yet, this critical issue is often overshadowed by the debate over total immersion versus transitional bilingual education as the medium of instruction. The point is not the medium of instruction.

It is whether the school shows a genuine respect for other cultures and encourages children to develop their home language as well as English. The majority of Chinese Americans are immigrants (Lee, 1982; Liu & Fernandez, 1987) whose first language is not English. If the school treats their home language as something to be weaned, their children will sense that there is something "unacceptable," "uneducated," or "inferior" about their roots. Unfortunately, this is the experience of many Chinese American children. Many will use their home language less and less even outside the school setting, seeing it as a sign of ignorance (Hong, 1989; Sue & Sue, 1993). By fifth or sixth grade, they will stop speaking Chinese. Even at home, when their parents address them in Chinese, they will respond in English as long as their parents can understand them.

The school environment is emphasized because of the potency of its influence on children's social and emotional development, as well as on their subsequent achievement. However, other institutions also have a role. To what extent are mainstream institutions, including the mass media, sensitive to one's culture and language? Are they sending messages that elements of Chinese culture are oddities, belonging only to the ethnic enclaves? Again, the answer is usually in the negative. Because of their experience with the school and with the mass media, many Chinese American children are ashamed of their cultural heritage, wanting to dissociate themselves from their community (Hong, 1989; Sue, 1989; Sue & Sue, 1993). Take for example, a Chinese high school senior referred to a community clinic for counseling. She was feeling like a failure because she had been turned down for admission by an Ivy League university. The school counselor referred her to the community clinic, hoping that a Chinese counselor could address her issues within the context of Chinese culture's high value on education. However, to the student, the referral added insult to injury. She took pride in being seen as mainstream and found it "degrading" to be regarded as so "Chinese" as to require services from a Chinese provider or from a community clinic.

For Chinese American children, the cultural gap between the home and the external environment is a major obstacle in the development of their self-esteem and identity (Hong, 1989; Sue, 1989; Sue & Sue, 1993). For parents who are less assimilated into mainstream culture, the cultural gap between them and mainstream service institutions makes it difficult for them to offer guidance to their children (Hong, 1989; Lee, 1982). This is a major blow to their self-efficacy as parents. Unfortunately, many schools and institutions, wittingly or unwittingly, have been playing a significant role in undermining the self-esteem of both children and parents, placing many immigrant Chinese American families at risk of becoming dysfunctional.

Cultural Gap Between Parents and Children

The immigrant Chinese American family is often a multicultural entity. The members identify, in various degrees, with their original culture and with mainstream American culture (Hong, 1989; Hong & Ham, 1992; Lee, 1982; Sue & Morishima, 1982). Typically, the parents, having lived for a longer time in their native country than their children, are more closely identified with Chinese culture. They tend to have stronger memories and emotional ties to their cultural roots. The children, who came to the United States at a much younger age, have much less direct exposure to their culture and country of origin. Attending school in the United States facilitates their exposure and their assimilation into mainstream American culture. Therefore, over time, a cultural gap will evolve between children and parents.

Frictions generated by this cultural gap might be manifested in different ways (Hong, 1989; Hong & Ham, 1992). For example, under the influence of Confucianism, Chinese culture emphasizes the hierarchical structure of the family, highlighting the importance of parental authority and of lifelong filial piety. As opposed to this, mainstream American families tend to be more egalitarian. Mainstream American teenagers typically have greater autonomy than Chinese American teenagers. Thus, Chinese American adolescents might complain that their parents are too strict, too dominating. In contrast, the parents might feel that their children are being disrespectful or defiant. Chinese culture emphasizes familism, collective duty towards the family, while mainstream American culture emphasizes individualism. Therefore, Chinese American young adults who wish to move away from home in order to become more "independent" might view their parents' objection as "old-fashioned." Many might even perceive their home culture as "backward" or "inferior." It becomes something they resent. The parents, however, might feel that their children are abandoning them as well as their cultural heritage. Such differences in cultural expectations could be very disruptive for the family, possibly resulting in despair and mutual rejection among members.

Social and Environmental Factors

The cultural gap between Chinese American parents and their children compounds the problems associated with their natural age or generation gap (Hong, 1989). Other social and environmental forces could further complicate the situation, creating additional stress. Racism and cultural/ethnic stereotyping are factors which greatly contribute to the stress for the family (Brand, 1987; Chua-Eoan, 1990). Although Chinese American children might more easily assimilate into mainstream culture than their parents, they often find others treating them in a stereotypical manner. For example, people might expect them to be fluent in Chinese or to be living in a "traditional Chinese" environment. Teachers might expect them to be high achievers as is the "typical" Chinese student. Acquaintances might ask them to talk about their country of origin even if their knowledge is limited. Given the prevalence of both the blatant and the subtle forms of racism in society, many will eventually find that, regardless of their actual degree of assimilation into mainstream culture, they will never be accepted as "full Americans" by others (Chua-Eoan, 1990). They often find themselves in a marginal position between two cultural identities (Hong, 1989; Sue, 1989; Sue & Morishima, 1982; Sue & Sue, 1993), as denoted by the term "juk sing," Chinese slang for "American-born Chinese," meaning a bamboo pole which is closed off at both ends. Having abandoned their roots, they are rejected by the group they seek to embrace. Such confusions and disappointments could be devastating for youths going through the developmental stage of individuation and identity development. This may readily lead to dysfunctional situations.

Empowerment as a Counseling Strategy

Schematic Representation of Empowerment and The Cultural Gap

Given the sense of marginality and powerlessness that might be generated by both aspects of the cultural gap, empowerment is an important concern in counseling immigrant Chinese American families. Here, empowerment refers to helping parents and children develop a better sense of self-efficacy and self-esteem as they strive to persevere and develop in the host American society. It involves closing the cultural gap within the family, allowing members to understand and to relate to one another as parents and children in a functional family. It also involves closing the cultural gap between the home and the external environment. As a result, family members do not need to feel ashamed or inadequate because of their minority cultural heritage.

A vivid way of conceptualizing the cultural gap in the immigrant Chinese American family and the strategy of empowerment is to schematically depict the situation as a zipper (Figure 1A). Assuming the developmental approach, a family begins as a single unit, a closed zipper. Parents and children are united as a system, interlinked, but not enmeshed. Each party has a defined position in the family. As time passes, parents and children move apart in culture and identity. This is like a zipper that is being zipped apart (Figure 1B). Instead of being one unit, they are becoming two separate entities. Empowerment, as an intervention strategy, is the sliding tab used to zip the two parts together again (Figure 1C).

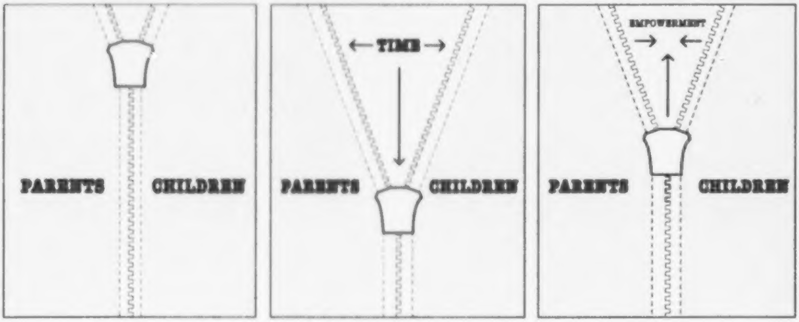

FIGURE 1 A FIGURE 1 B FIGURE 1 C

ZIPPER MODEL OF EMPOWERMENT AND THE CULTURAL GAP
IN THE IMMIGRANT CHINESE AMERICAN FAMILY

Since the cultural gap within the family is closely related to the cultural gap between the home and the external environment, one must address both issues in order to close this schematic zipper. In general, closing the cultural gap within the family is secondary prevention; closing the cultural gap between the home and the external environment is primary prevention. In actual practice, of course, there are overlaps between the two.

Primary Prevention:

Closing the Gap Between Home and External Environment

In terms of primary prevention, empowerment involves the creation of an environment in which Chinese American children would not feel shameful of their home culture, and where service providers would not, consciously or unconsciously, convey the message that their cultural heritage is inadequate or inferior to mainstream culture. While the external environment includes practically all settings outside of the home, this discussion will focus on institutions where counselors function, and where they could make a major impact. These institutions include schools, mental health or social service centers, and other community agencies. Among them, the schools again deserve special attention, given the potency of their influence, as explored earlier.

The school is a setting in which mainstream culture and language are upheld as the tool for social mobility. However, this can easily be distorted to convey the message that other cultures and languages are less useful, and hence inferior (Gollnick & Chinn, 1990; Macedo, 1991). In order to correct this bias, counselors and other mental health professionals working in schools should collaborate actively with teachers and staff to ensure that cultural diversity is affirmed. Multiculturalism has to be included in the curriculum. This is in addition to the social activities sponsored by the school (Gollnick & Chinn, 1990).

Specific services that counselors, school psychologists, and other mental health professionals can provide include preventive counseling groups for bicultural/bilingual students and cultural sensitivity workshops for staff, faculty and students. To maximize the preventive impact of these services, they should be provided on an ongoing basis at different grade levels, therefore, addressing issues relating to the students' different developmental stages. A well-planned program introduced promptly to a school's newcomers may play an important role in preventing problems at a future date.

In addition, parenting groups or workshops are also very useful. This service might be implemented through weekly group sessions over two, three months for small groups of parents, or through large scale workshops offered monthly or bimonthly focusing on specific topics dealing with parenting in the context of Chinese and mainstream American cultures. These groups and workshops bridge the gap between the home and the external environment by helping parents gain a better understanding of the mainstream culture and the institutions. This makes it easier for parents to collaborate with the school in their children's education. In working with parents, bilingual services are crucial, for there is a large number of immigrant Chinese American parents, especially those from lower socioeconomic status backgrounds, whose fluency in English is limited. Without bilingual services, many Chinese American parents will feel intimidated by the school and might resign to taking a minimal involvement in their children's education.

While the above suggestions focus on the school setting, many of them are also relevant to other institutions. For example, preventive counseling groups for children and parenting groups or workshops could be provided in social service agencies, counseling centers, and even hospitals with primary prevention programs. Cultural sensitivity training and bilingual services are equally important in all these institutions. By closing the cultural gap between the home and the external environment, one helps to minimize the cultural gap between parents and children. Preventive work can preserve much effort in dealing with a dysfunctional family in the future.

Secondary Prevention:

Closing the Gap Between Parents and Children

Secondary prevention is concerned with treatment after a problem has occurred. Dysfunctional situations in the immigrant Chinese American family, like those in mainstream families, might be caused by a variety of factors, such as personality, environmental, or life issues. In some cases, the cultural gap between parents and children might simply be a contributing factor, adding to these problems. In other cases, this cultural gap can be the central issue. However, regardless of the situation, the counselor will likely have to address the cultural issues at some point in the counseling process.

In closing the cultural gap within the family, it is important that the counselor avoids taking sides and, subtly or blatantly, favors one culture over the other (Hong, 1989). At times, such biases might take the form of over-emphasizing the utilitarian aspect of mainstream culture. Other times, they might take the form of over-romanticizing Chinese culture. In addition, non-Chinese American counselors need to be careful about over-compensating for their potential ethnocentrism by forming a bias in favor of the Chinese culture. Similarly, Chinese and other Asian American counselors must be alert to the possibility of countertransference associated with their own cultural identity issues. Such biases could easily permeate into a counseling session without the counselor being aware of them.

For parents, the strategy of empowerment involves enhancing their own self-efficacy in taking charge of their own family by informing them about mainstream culture. Immigrant parents, who are less assimilated into mainstream American culture, are often at a loss in dealing with their children's problems. Many of them know that it is inevitable for their children to become more "American" than themselves. However, they are unsure about which is truly mainstream culture, or about those aspects which are proper or improper. For example, is heavy metal music acceptable? How about dressing in punk style? Experimenting with drugs? With sex? When their children accuse them of being old-fashioned and narrow-minded, where do they draw the line? In the face of uncertainty about the value system or about the moral standards in mainstream culture, some parents might assume a defensive stance, rejecting mainstream American culture as being corrupt, unacceptable. Such a stance might alienate the children, inspiring outright rebellion. Other parents might simply despair and give up on trying to influence or guide their children. Many parents are resigned to allow their children to grow up and become "whatever they happen to be." This is typically negative.

An essential part of counseling Chinese American parents is to provide them with information regarding mainstream culture. Community resources such as adult English classes, acculturation and parenting groups, or social services, are often important aspects of counseling. By improving their understanding of mainstream culture, parents may regain their efficacy in dealing with their children's issues. The parents would also better understand and better relate to their children. On a different level, the counselor must empower parents by affirming their home culture. One needs to reassure parents that they are not "old-fashioned," "culturally inferior," or "culturally deprived" because of their cultural identification. At the same time, one needs to help parents move through the cycle of grief, or sense of loss, to the stage of accepting the reality that their children will be more "American" than they are themselves. Instead of seeing this as a failure, the parents could do their best to ensure that their children will benefit from the best of the two cultures.

A major aspect of empowerment involves helping the children resolve the identity issues which they might be experiencing. Regardless of the culture with which they overtly affiliate, it is hard for Chinese American youths to be completely free from the influence of either culture. The counselor should be sensitive to their biculturalism (Hong, 1989; Sue & Morishima, 1982), and the associated feelings of marginality and alienation. One should affirm their home culture, helping them to recognize that they do not have to be ashamed of their cultural heritage or of their parents' lack of assimilation into mainstream culture. At the same time, they need to be assured that they do not necessarily have to embrace their culture of origin as closely as their parents. However, the counselor needs to help the children understand the cultural basis of their parents' perspectives and expectations. When they lower their defensiveness, many children can often appreciate their parents' good intentions. Together with comparable changes on the parents' part, the two parties will have a good chance to compromise and meet each other, giving and taking, on some common ground (Hong, 1989). In this way, the "zipper" may be closed, and the family will be on its way to becoming functional again.

Conclusion

In order to provide effective counseling services to the immigrant Chinese American family, counselors must go beyond traditional clinical techniques to infuse a cultural dimension into their work (Hong, 1988, 1989; Lee, 1979, 1982; Sue & Morishima, 1982). They need to go beyond treatment to include prevention, and beyond the therapy model to include education and advocacy models. The schematic conceptualization of the issues in the Zipper

Model will help counselors and other mental health professionals to take a comprehensive perspective in planning their services.

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> *If the doors of perception were cleansed*
> *everything would appear to*
> *man (sic) as it is, infinite.*
>
> –William Blake, *The Marriage of Heaven and Hell*

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Influences on the Philosophy and Practice of a School Counselor: A Personal Perspective

George F. DeHaas

This article summarizes various influences on the development of one school counselor's philosophical approach and practice. The author, a recently certified school counselor, presents a perspective on how graduate education, personal growth experiences and networking for supervision and consultation combine to provide focus for counseling activity in a school setting. The article points to the importance of including family members in school counseling efforts, cognizance of the impact of parental substance abuse on a child's life, the value of the application of common sense principles and the usefulness of action as a counseling goal. Counselor education is presented as an ongoing, active process which benefits from the individual's utilization of many different resources.

FOCUS ON ACTION

Gerard Egan (1990) notes that "Overstressing insight and self-understanding can actually stand in the way of action. The search for insight can become a goal in itself" (p. 187). That particular idea is very important as I identify my counseling philosophy. As I continue to work in a school setting (K-12), encouraging action over insight (for its own sake) has become central to my efforts with students, teachers, and parents.

Egan (1990) also notes that if pain is to be turned into gain, behavioral change is required—whether the behavior is internal, external or both. Regardless of one's age or circumstance, the pain of living most likely won't subside unless one DOES something. Some insight is important as it may lead to discoveries about how to create positive change. However, for most of the problems in living that individuals bring to a school counselor's office, energy often seems better spent in action planning rather than searching for the origins of the pain.

One basic approach to developing an action orientation in a counseling setting was presented in one of my initial graduate counseling courses. The instructor indicated that a counselor would do well to utilize the following sequence of questions as he/she works with a client:

What would you like to do?

What are your resources?

What is in your way?

How can I help you?

Obtaining answers to those four questions can take varying amounts of time, energy, and expertise, but the focus on reaching an action point is clear. Those four questions are posted on the wall in my office, and keep me focused at times when I might tend to get caught in an "all talk and no action" mode with a student.

Keeping the action/doing focus is helpful in counseling students, teachers, and parents. While I don't discount that just the "telling" of a problem or personal story is important, and even therapeutic, I've noted from experience that some clients' interest in the counseling relationship often wanes or ends when they're nudged or pushed toward doing something about their issues. That is a good clue to me that either they are not very serious about the complete counseling process or they need time to discuss the issues further. While I stress action, I also realize that insight is essential and cannot be taken for granted.

Virginia Satir (1972) states that "there is always hope that your life can change because you can always learn new things" (p. 27). But, she cautions that knowing change is possible and being willing to make change happen are operations that must be accomplished before learning can be utilized. Satir stresses the importance of educating ourselves for change. In *Peoplemaking*, she describes many activities which enhance that education. She views teaching as an integral part of counseling. Activities such as "back-to-back communication" and "blamer-placater-distracter" teach new ideas and provide an avenue for change. I find these activities to be helpful in moving clients toward action.

Satir's belief in the power of communication in human relationships has also been a source of inspiration. The action-oriented nature of her games, role-plays and exercises meshes well with my own penchant for activity in counseling.

I often draw upon Satir's exercises for improving communication and internalize her statement that "communication is the greatest single factor affecting a person's health and his (sic) relationship to others" (p.58). These exercises have been useful to me in working with individuals, small groups, couples and families.

FAMILY INVOLVEMENT

One aspect of my counseling philosophy that has taken on a more substantial role in recent years is the engagement of family members other than the primary client in the counseling process. I've observed that elementary school children often may not exhibit behaviors in school that are similar to behaviors which concern their parents. Often, parents will call with concerns relative to their child's home behavior, and express disbelief if school behaviors don't match those at home. In order to make sense of that discrepancy, I ask parents to come for a conference.

I find support for this approach in both Goldenberg & Goldenberg (1991) and Nichols (1992). The Goldenbergs, via their discussion of Bowen, Minuchin, and others, propose that the identified patient in a family is only a symptom of the difficulties in the entire system. Even within the limitations of the school counseling setting, it is possible to begin doing triage on the family problems that are contributing to a child's behavior.

The difficult part is presenting the fact that maybe the school isn't the *main* problem. Parents who are anxious and upset about their own situations are not always eager to share the burden of action to help their child. (It would be so much easier if the school would just take care of the behavior problems.) Often, acknowledging to an anxious parent that it *is* difficult to raise children is an important first step toward getting their cooperation in working to help the child.

Nichols (1992) notes that the family is indeed a system, and that "A system is more than the sum of its parts; it is the parts plus the lawful (ordered) ways they function together. Because everything that anyone in a family does affects the whole system, almost any change will affect all members of a family and the way they function together" (p. 68).

A great deal of the work I do in school is related to the impact of those changes on the family system and its individual components. To attempt to counsel a youngster isolated from information about how his/her family functions would be difficult at best. A teamwork approach is more productive than working in isolation.

PROFESSIONAL INTERACTIONS

An important counseling belief that I translate into practice is that consulting with other professionals is prudent and necessary. Assessing human behavior and motivating people to act is difficult, but doing those things without professional support is even more difficult and counterproductive.

Egan (1990), Nichols (1992) and O'Connor (1991) point to the benefits of consultation in a counseling practice (school or other setting), and my experience over the past eleven years supports that viewpoint. Professional counselors can support each other via writing, direct consultation, or phone networking.

Consultations provide new ideas, critiques, and reinforcement for work in progress. These professional interactions also are valuable referral resources when the limits of skills and energy are reached. Additionally, consultations reduce the feelings of frustration and isolation that counselors may experience. In addition to consultation, supervision is also an excellent avenue to developing clinical skills. The more one participates in clinical supervision and practica, the better counseling technique becomes.

In clinical supervision, a counselor has the opportunity to present material and receive feedback on his/her counseling style and technique. For example, the audiotapes I submitted at the beginning of a graduate practicum were slow and my interviewing style was plodding. Without the benefit of supervised experience, I would have assumed that my pacing was good, and may not have worked to improve it.

THE IMPACT OF ADDICTION

A significant percentage of my counseling time is spent dealing with the issues surrounding the impact of alcoholism and other addictions or substance abuse problems on individuals and groups. In this aspect of my work, I subscribe to five operating principles that Deutsch (1982) cites as helpful to professionals who work with children from alcoholic families:

1. Help is a process.
2. Help is often invisible or in disguise.
3. Help is not necessarily a dialogue
4. Tone is more important than content.

5. Helpers' responses are more than what they say. (p.117)

Deutsch (1982) points out that "inconsistency is the hallmark of most active alcoholics" (p. 41). Therefore, it is essential that a counselor who works with children of alcoholics is consistent. Deutsch indicates that *inconsistency's offspring is insecurity* so insecurity can become a way of life for a child with an alcoholic parent. Since the non-alcoholic parent often behaves inconsistently as well, these children may look to others in their world for a sense of stability and security. Often, I find that the children from the most addicted homes become the most anxious when their teacher is absent or there are other variations in the daily routine. If school counselors can assist in the maintenance of order and consistency for these children, the children are well-served.

Patience is a key in working with children of alcoholic family systems. A child who has found it difficult to trust members of his/her own family will not always be open to developing a relationship with a counselor. Children who have learned to bury their feelings deep inside may have to be taught how to express them in healthy ways. Additionally, children of alcoholics can benefit from the day-to-day presence of a counselor.

In discussing realistic goals for counseling children of alcoholics, Deutsch (1982) indicates that it is indispensable to "express concern and a willingness to listen in complete confidence." (p. 124) This serves to remind me that trust can be built in simple, yet powerful ways.

Deutsch (1982) also believes that children from alcoholic family systems are not victims, but survivors. They certainly aren't crazy because they have found sane ways to live with the craziness of the alcoholic. I admire and often applaud their resiliency. In my counseling practice, I engage these youngsters in the pursuit of healthy alternatives. For example, I teach basic chess to third and fourth grade children of alcoholics, volunteer in a school-based mentoring program for middle school students, and work with adolescent children of alcoholics on peer leadership presentations. I also work to educate other staff members about some of the issues that children of alcoholics face in their school and personal lives.

Woodside and Brown (1989) note that one out of every eight Americans is the child of an alcoholic, and that seven million children of alcoholics are under the age of eighteen. These numbers literally guarantee that there will be students in every classroom who are coping with parental alcoholism. Teachers who are knowledgeable about alcoholism, and sensitive to the particular needs of children of alcoholics are valuable allies to counselors and their clients.

PROFESSIONAL EDUCATION AND PRACTICE

After receiving the title of *counselor* (with little formal training) eleven years ago as part of a state-funded drug prevention program, I began to educate myself via workshops, reading and consulting with others in the field. In 1992, I enrolled in the graduate program at SUNY Oswego to pursue a degree program in counseling. Over the years, I have counseled hostile adolescents, angry teachers, frightened first first graders and frustrated parents. I have constantly explored new ways to deal with these diverse challenges.

In my practice, I employ a mixture of techniques and activities with clients. For example, I use table games such as *Memory*® (in which pairs of pictures are matched by turning cards over) and checkers as avenues to talking with children in the primary grades. With older elementary and intermediate school students, I have games such as *Uno*® (a card game in which numbers and colors are recognized) and *Ungame*® (a social skills game with a focus on identifying and expressing opinions and feelings) available for lunch time, group and individual sessions.

O'Connor (1991) provides practical guidelines on selecting play materials that are developmentally appropriate and attractive to children. For example, I have stuffed animals and puppets that primary students use to express their feelings through fantasy and creative play.

Various types of art materials are also available in my office. As O'Connor (1991) notes, children develop more sophisticated skills of artistic expression as they grow. Felt markers and drawing paper may work well with students in grades K-2, but older children will want to use materials such as clay and plastic building blocks. O'Connor (1991) states that as children develop their expressive powers, they move from solely two-dimensional art activities to three-dimensional ones, so I provide the appropriate media.

Some activities that I utilize in counseling adolescents come from my experience in a clinical supervision group. M. McHugh's (personal communication, May, 1993) storytelling skills and her descriptions of art experiences in a therapeutic setting have been very informative. Some of her techniques have been immediately useful with my clients. For example, she demonstrated a storytelling closure activity which I utilized with an adolescent group. The activity involved having each member select a metaphor to represent a "good-bye" to the group. Each person then wrote a short story. The stories were shared at the final meeting, and they provided a unique, personal way to close the year.

Perhaps, the most beneficial aspect of McHugh's supervision has been my enhanced respect for the value of self-expression in counseling. According to

McHugh (personal communication, October, 1992), art and storytelling (much like play therapy) have boundaries and directions, but basically allow individuals an opportunity to share issues in their own way. The counselor can act on what is being expressed and engage the client in more self-discovery. This serves to minimize the likelihood that counselors will impose their own agenda on clients.

Another technique that I have found useful with student clients is genogram construction. McGoldrick & Gerson (1985) identify an ordered way to develop genograms and to utilize them as assessment tools. They base their ideas on the concept of a genogram as an "interpretive tool" which can be used for understanding a family in a systems perspective.

McGoldrick & Gerson (1985) stress the importance of looking for patterns in families and having clients assist in identifying familial sources of tension and conflict. They also suggest that the visible and tangible nature of the genogram may give clarity to family structures that are incompletely described in an interview. The neutrality of the picture/map may also ease the apprehension that a client may have about discussing family issues.

For example, I was working with a ten-year old client, and the process seemed to be moving slowly. He denied that any issues were troublesome for him. I decided to change direction, and we began to draw a three generational genogram. This client became quite anxious when he started to discuss his grandparents. Via the neutral medium of the diagram, he was able to begin to talk about the tension between an abusive grandfather and his own father. He was quite fearful of his father, and couldn't separate the various relationships. The symbols on the paper provided him with a safer, less threatening means of self-exploration.

In summary, I want to note the title of the first book on counseling that I read. It was in 1978 and I was preparing for a voluntary internship with a county mental health department's crisis intervention team. The title of the book by Eugene Kennedy (1977) was *On Becoming a Counselor.* The word *becoming* impressed me then and it still does today because it reflects my belief—and my experience—that counseling is a dynamic activity. Counselors must be willing to grow and change. To provide effective services to our clients and to our profession, we must work from philosophies that complement our own particular styles and which are based on education, consultation, supervision and experience.

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Effective Changes in Admissions Requirements and Procedures in a CACREP Accredited Masters Program

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Tracy D. Bostwick Baldo

This article presents a currently implemented admissions process which has effectively reduced the number of inappropriate admissions to a CACREP accredited masters program. Admissions criteria and procedures are detailed.

The process of counselor education admissions has been the topic of research for the past 40 years (Gimmestad & Goldsmith, 1973; Harvancik & Golsan, 1986; Hosford, Johnson, & Atkinson, 1984; Markert & Monke, 1990; Walton & Sweeney, 1969; Wellman, 1955). Lamb, Presser, Pfost, Baum, Jackson, and Jarvis (1987), in referring to the Association of Counselor Education and Supervision (ACES) and the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) ethical guidelines, remind counselor educators that it is also their ethical obligation to screen students who have "an inability to control personal stress, psychological dysfunction, and/or excessive emotional reactions that interfere with professional functioning" (p.598). Often the screening of counselors-in-training occurs in practicum and internship where the supervisors have the opportunity to observe the students and have more information on their psychological functioning (Bostwick, 1993). Due to the already intense nature of practicum and internship, "inappropriate" trainees become an even greater emotionally and temporally demanding responsibility. Clearly, screening applicants effectively before they are admitted would benefit both counselor educators and prospective students.

Some researchers have studied the effectiveness of using grade point averages (GPAs) and traditional aptitude tests such as the Graduate Record Exam (GRE) and the Miller's Analogy Test (MAT) (Bergin & Solomon, 1963; Carkhuff, 1969; Harvancik & Golsan, 1986; Hosford et al., 1984); however, these variables have not proven effective in predicting academic success or counseling skill attainment (Markert & Monke, 1990). Other admissions criteria utilized by counselor education faculty have included personality variables such as the Minnesota Multiphasic Personality Inventory (MMPI), the 16 Personality Factor Questionnaire, the Edwards Personal Preference Schedule; however, as stated by Carkhuff (1971), there is no validity for using personality tests to identify persons that function at a high interpersonal level. The Kagan Affective Sensitivity Scale and the Carkhuff Index of Communication scales appeared to be promising initially, but later research has shown the effectiveness to be marginal (Markert & Monke, 1990). In actuality, counselor education faculty continue to struggle with identifying effective admissions screening criteria (Markert & Monke, 1990).

In 1991 the University of Northern Colorado (UNC) Counselor Education faculty reevaluated its current admissions policy to more effectively screen applicants who would be successful in "nonacademic" courses (i.e., counseling practicum). At that time, of the approximately 100 applications being received at UNC, 40-50 students were admitted. Of the 40-50 new admits, the university found approximately four or five students who clearly should not have been admitted. Once they were enrolled in practica coursework, it became apparent that they had difficulties either with controlling interpersonal stressors or had emotional reactions that interfered with their professional judgement. A 90% success rate was not satisfactory, because the 10% "failure" rate meant a great deal of faculty time and resources were used for extensive individualized training or providing documentation for non-academic terminations. A new method of screening applicants was needed.

A process was begun to evaluate the current admissions process and to suggest possible methods of revision. Based on the previous published admissions research (Hollis & Wantz, 1986; Markert & Monke, 1990) and phone interviews to other universities with counseling programs, a revised admissions policy was developed which has proven very effective. Only one "inappropriate" student, (i.e., who was unable to manage personal stressors and who had excessive emotional reactions that interfered with interpersonal and professional functioning and training), was admitted over the past two years out of over 200 applicants and 100 admissions. There was a change from a 90% "success" rate to a 99% "success" rate. In other words, 99% of the admitted students were successful in both academic coursework and clinical nonacademic coursework.

Since counselor educators have been struggling with finding an effective admissions policy, this article will present the University of Northern Colorado's revised admissions process which may offer suggestions for other universities' admissions committees.

New Admissions Policy

Some of the previous admissions requirements were perceived as beneficial and were not revised. These included letters of recommendation, two years of work experience post-baccalaureate, and the Supplementary Data Form. Three copies of a specific recommendation form, for consistency, were included in all application packets. The recommendation form included ratings on characteristics such as empathic capacity, ability to work closely with others, and personality characteristics which could interfere with the applicant's ability to work effectively with others such as hostility, fearfulness, and seclusiveness. Another admissions requirement was a minimum of two years of work experience post-baccalaureate if they were considered a traditional student (i.e, if they completed their BA or BS degree before the age of 25). For persons who received their baccalaureate degree after the age of 25, the work experience requirement was waived. A Supplementary Data Form, or application, was also required and asked applicants to report on their interests, self-perceptions, and professional aspirations.

The grade point average (GPA) requirement was slightly revised from a 2.7 or higher on the last 67 hours of coursework to 3.0 or higher on the last completed degree. This was not a departmental decision, but rather a mandate by the University Graduate School. The previously required MMPI was replaced by the MMPI-2 because of the availability of a mental health professionals norm group for comparison rather than the clinical population used by the MMPI.

The major change in the admissions process was in the day on campus, or "workshop". Applicants were required to attend a full day workshop which included an introduction to the program and faculty, small group activities and interviews, a tour of the counseling facilities, and the administration of the MMPI-2. Following a one-hour introduction, applicants were placed in a small group of four to six persons. One of the applicants was given a brief description of a controversial client issue and asked to role play. For example, one of the client scenarios used was, "You have been married 18 years and just heard from a friend that your spouse has been having an affair with your neighbor. Supposedly the affair has been going on for about 3 months, and you thought your marriage was just fine. You have not confronted your spouse because you are not sure if you believe your friend". One of the applicants seated across from the "client" was assigned to play the role of "counselor". All applicants were informed that they were not expected to be master counselors. They were asked to respond to the client in a manner in which they believed to be therapeutic. The role play was run for five minutes. During this time the remainder of the applicants in the group observed the interaction. Following the role play, ten minutes were given for all group members to discuss their reactions and offer feedback. The main purpose of this activity was not to evaluate counseling skills, but to assess the applicants' interpersonal skills, prejudices, openness to feedback, etc. Each group member was required to play both the role of client and counselor as well as participate in processing the interaction. This activity lasted approximately one and one-half hours. Following the role plays, the applicants remained in the same groups for a one hour interview process. Applicants were asked five questions which were revised from the previous admissions procedures. The interview questions included such topics as identifying something unique about the applicant that they had to offer the counseling profession as well as identifying characteristics about themselves that they would have to change in order to be an effective counselor. Following the interviews, each group member completed a sociogram based on their observations from the role plays and interviews. The sociogram asked the applicant to state whom they would go to first in their small group if they were in need of counseling and why, then whom they would go to second and why, etc., until all members were rank ordered. Also on the sociogram, each group member was given an overall score on a scale from 1 (highly ineffective) to 10 (highly effective) for how effective they were perceived to be as potential counselors.

At least two faculty were assigned to observe each small group interaction and remained with the same group throughout the role plays and interviews. Therefore, the same faculty had at least two and one-half hours with four to six applicants which allowed for a longer observation time. Following the interviews, while the applicants were completing the sociogram, the faculty were writing evaluations of the applicants based on their observations of the role plays, discussions, and interview responses. The evaluations used a 4 point scale from "poor" to "very good" and included the following ratings: tolerance of individual differences (no readily apparent biases); able to intelligently and thoughtfully discuss the concerns expressed by the "client" in the role play; interacts appropriately with other group members - tolerant of others' opinions; maturity (individual has experienced life); and a prediction as to the success of the person in the practicum class. Space was given for evaluators to list the applicant's strengths and weaknesses. Finally, the evaluator gave an overall rating from one to four of the individual.

The rest of the workshop day was spent touring the facilities, allowing applicants time to interview current students, and administering the MMPI-2.

The Decision Process

Each applicant's data was placed and summarized on a spread sheet. The faculty ratings from the group interaction and interview were averaged and each applicant was given a numerical score. Scores below 3.0, or good, were considered low. A numerical score for each applicant was also obtained by averaging the results from the sociogram. The MMPI-2 was rated as "OK", "For Review", or as "Reject". Work experience was evaluated as "OK" which meant the applicant had a minimum of two years of work experience post-baccalaureate, or "Deny". Applicants not meeting the work experience requirement were screened prior to the workshop. Letters of recommendation were evaluated as "OK" or "?". A "?" was given when the letters indicated concerns as to the applicant's capacity to become a counselor. The applicant's GPA from their last completed degree was listed as is. Finally, reviews of Supplementary Data Forms were evaluated for obtaining a clearer understanding of the applicant's goals. If the applicant's goals were consistent with the program goals, they were marked as "OK".

Applicants meeting all admissions requirements completely were admitted. As indicated previously, all applicants not meeting the work experience requirement were automatically denied admission. Applicants scoring low in both faculty ratings and sociogram ratings were automatically denied admission. Any applicant not meeting the criteria in any three areas was also denied admission. Any GPA below 3.0 was "flagged" for further review. GPAs below 2.5 were automatically denied from participating in the workshop and were denied admission. Applicant's MMPI-2 profiles that indicated strong concerns in the areas of openness to evaluation, social facility, and overall adjustment were denied. The remaining applicants who did not meet the criteria in only one or two areas were discussed by the admissions committee. Faculty ratings and sociogram ratings were weighed very heavily. Low scores in even one of these areas were highly likely to be cause for denial. The Supplementary Data Form and the letters of recommendation were reviewed more thoroughly when an applicant fell on the border of being admitted or denied.

Conclusion

A number of factors may have contributed to the greater screening effectiveness, rather than any one factor in particular. Specifically, the increased amount of time to observe applicants in small groups may have increased the accuracy of faculty observations and sociograms. The addition of controversial topics for role plays and discussion may have led to greater insight into the open-mindedness versus the biases and prejudices of applicants. The greater interaction time for getting to know group members through role plays in the counseling role, client role, and observer/feedback role, possibly led to more accurate evaluations on the sociograms and faculty ratings. Finally, it may seem contradictory to use the MMPI-2 when the literature has shown that personality variables, as measured by instruments such as the MMPI, may not prove helpful in predicting interpersonal effectiveness (Carkhuff, 1971). However, the new factors of openness to evaluation, social facility, and overall adjustment, assessed on the MMPI-2, when combined with the other measures for a more holistic and global picture, may have increased the effectiveness of the admissions process.

While the majority of students are successful academically, most inappropriate admissions involve poor interpersonal skills (Bostwick, 1993). Clearly, gaining insight into applicants' interpersonal skills is an asset to screening for nonacademic concerns. This admissions process places a strong emphasis on interpersonal insight and appropriateness. The admissions outcomes are supportive of this emphasis.

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> *A right is not what someone gives you: it's what no one can take from you.*
>
> –Ramsey Clark, in New York Times

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4. Begin the abstract on a new page, and identify the abstract page with the running head and the number 2 typed in the upper right-hand corner of the page. The abstract should be approximately 125 words.

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Message From the NYCA President:

"The 80/5 Dilemma"

David M. Kaplan

In his 1970 book, *Future Shock*, Alvin Toffler predicted that a great challenge in upcoming decades would be to digest the huge amount of information which would be coming with sophisticated information technology. In the profession of counseling, Mr. Toffler's famous prediction has come to pass in what we now know as the "80/5 Dilemma". This dilemma states that 80 percent of everything we know in counseling becomes obsolete every five years.

The "80/5 Dilemma" provides quite a challenge for counselors who wish to base their interventions and strategies on our current knowledge of what works best for a particular client in a particular situation. *The Journal for the Professional Counselor* is a vital source in this quest to stay current and avoid obsolescence. Long renowned as one of the best (if not *the* best) of the state branch journals, *JPC* helps keep counselors from all specialties up to date on a wide variety of issues and problems faced by our clients.

In continuing its level of excellence, *JPC* recently was awarded the 1996 first place journal award from the American Counseling Association. I congratulate Terry Bordan and the entire editorial board on this well deserved recognition.

The Journal for the Professional Counselor is a vital resource in effectively dealing with the "80/5 Dilemma" and therefore, is one of the most important services provided to you by the New York Counseling Association. I am proud to be associated with it.

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Establishing a Successful Private Practice: Some Practical Considerations

Terry Bordan
Marjorie S. Demshock

Ways and means of starting, building, and maintaining a successful private practice are detailed in this article. Attention is given to building a client base, choosing an optimum location, networking, marketing, and insurance reimbursement.

Contrary to what some might suppose, a successful private practice depends less on the counseling skills of the individual counselor and more on his or her knowledge of marketing, advertising, networking, and self-promotion. Successful private practice is a business and must be planned accordingly. This article will discuss some of the considerations a counselor must take into account in establishing, building, and maintaining a part-time or full-time private practice.

Initially, the counselor will see relatively few clients, but his or her efforts will be centered on developing a marketing and networking plan. Although counselors tend to be self-effacing and other-centered, the work of private practice is indeed a business. Some private practitioners hire consultants to take care of the business end of their practice. There are several publications (e.g., Psychotherapy Finances) which seek to inform counselors, psychologists, and social workers as to the "nuts and bolts" of billing, dealing with managed care, and advertising. Other researchers have suggested written guidelines delineating the structure of the therapeutic relationship (Weinrach, 1989).

Williams (1991) outlines three major tasks to be accomplished in developing a marketing plan. These include conducting a marketing audit, dividing the market into segments, and further demarcating the marketing mix. Other variables to be considered are client recruitment and fee structuring (Hill & Fannin, 1986).

The counselor considering starting a private practice needs to engage in self-assessment. Simply put, the counselor needs to determine where his or her experiences, interests, and training lie. Awareness of one's own personality and individual strengths is essential. For example, if he or she has prior background as an educator and is comfortable with public speaking, then the beginning practitioner may use these abilities to generate workshops and seminars for teachers, parents, and students. This mental health professional may then expand into other topics for employers, employees, and businesses. If the counselor has experience in the field of bereavement, he or she may market himself or herself to hospice programs, nursing services, and funeral homes. This interest in bereavement issues could then be extended to include other loss issues, such as divorce, empty nest syndrome, and work relocation. Thus, one ability or interest may be expanded upon to create an ever flourishing source of publicity and self-referral.

Another consideration is to assess the needs of the community in which the counselor hopes to practice. If the professional lives in a rural area where there are few other services, it is incumbent upon the counselor to work collaboratively with other professionals in the region. It is necessary to guard against conflicting advice and care with mutual clients (Kaslow & Steinberg, 1982). In small towns, the counselor often is known by potential clients and therefore has to be extremely careful in guarding against conflicts of interest. Regardless of the size of the community, the counselor needs to be vigilant to avoid undue dependence on his or her clients for fulfillment and validation (Tolor, 1982). If the clinician resides in an urban or suburban area, he or she needs to be aware of and assess the services offered by other clinicians and agencies which may compete with or complement the practitioner's own skills and abilities. An assessment of competing services may help the clinician to decide where to locate his or her practice. Areas with large underserved populations in the counselor's field of expertise may be ripe choices for opening a main or satellite office.

Not only does the clinician need to be aware of the general structure of the community in which he or she lives, the clinician must examine the issues being focused upon in the media and current sociological implications and trends. For example, as the population ages in a given community and schools close and are replaced by senior citizen centers, the practitioner may want to shift his or her emphasis from traditional family therapy to counseling that focuses on the needs of the "sandwich" generation (i.e., middle-aged adults caught between the needs of aging parents and their own children). If the cultural mix of a given community changes due to the influx of one or more immigrant groups, the skilled mental health professional may work to develop a more inclusive multicultural emphasis. This may lead to work in mediation between the diverging cultural groups in the community.

High visibility of the private practitioner is a priority in establishing and maintaining a successful practice. Television and radio interviews on local talk-shows are a quick way to reach a large audience of potential clients. The skilled professional can market his or her services through such timely topics as: "Surviving the Loss of a Love" (Valentine's Day), "Readjusting to School" (September), and "Fighting the Holiday Blues" (December). Posting meeting notices in the community calendar section of local newspapers is often a free source of publicity. Counselors with a more established practice may want to consider placing an advertisement in the county Yellow Pages (Psychotherapy Finances, 1991).

The mental health professional has several issues to consider in choosing the optimum location for a clinical practice. These include: hours of availability, access to public transportation, the presence of other related professionals, lighting, confidentiality, and cost of leasing (Gold, 1994). Some practitioners begin by sub-leasing space from a more established mental health professional. This can generate cross-referrals and the sharing of cases. Other clinicians may choose to see clients in the clinician's home. This choice must be made carefully especially when the counselor is dealing with clients with severe impulse control problems or those suffering from violent outbursts. Those counselors hoping to take the cost of their home office as a tax deduction need to review the Internal Revenue Services' code regarding home offices before renovating space in their home to use as an office (Psychotherapy Finances, 1991). A waiting room, available parking space, and access to a restroom are other considerations which need to be assessed.

Networking with mental health specialists and professionals in other related fields (i.e., medicine, education, law) is necessary in building a private practice. The successful practitioner understands the importance of listing his or her services with local hotlines which make referrals of potential clients in crisis. Joining local, state, and national organizations such as the American Counseling Association (ACA) and the New York Counseling Association (NYCA) provides private practitioners with an opportunity to meet counselors from different disciplines, to share resources, knowledge, and additional professional materials, to establish new relationships which will lessen the isolation experienced in a solo practice, and to ascertain information about supervision and the possibility of sharing office space. Furthermore, professional associations provide essential knowledge regarding the status of licensure in a particular state, obtaining affordable malpractice insurance and strategies for increasing third party reimbursement.

As more practitioners are reimbursed by a specific health care system, the demands for cost containment increase (Albee & Kessler, 1977). Mental health professionals frequently lack information regarding credentialling and licensure (Alberding, Lauver, & Patnoe, 1993). This lack of information severely limits their ability to obtain third party reimbursement and to obtain provider status with managed care panels. With the growing trend toward managed care, counselors need to increase their knowledge and skill in providing brief therapy, their familiarity with DSM-IV diagnostic categories, and their ability to interface with managed care personnel. Private practitioners receiving managed care referrals also need to allot additional time for processing paperwork.

Although contemplating entry into private practice can induce anxiety in the most skilled of professionals, the establishment and maintenance of a private practice is an ever evolving process. The tasks involved in developing a successful practice are daunting but surmountable when taken step-by-step.

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Bystanders: An Overlooked Factor in Peer on Peer Abuse

Richard J. Hazler

Peer on peer abuse among young people continues to increase even as other national crime and violence statistics are going down. Currently favored methods including: adult controlled actions, punishment for abusers, and support for victims have not proven successful in stopping this trend. This article draws attention to "bystanders" who are most often passively involved in the abuse, experience problematic consequences from the abuse of others, and have the potential to be a major force in changing these problem situations for the better. They make up the largest resource to go mostly untapped in the fight against peer on peer abuse. This article examines the problems bystanders experience and methods for encouraging their more productive involvement in stopping peer on peer abuse.

Frightening information about youth violence seems to bombard us daily. FBI statistics tell us that while criminal violent behavior in general is decreasing nationwide, youth violence and crime continue to explode (Los Angeles Times, 1995). Respondents from over 700 cities and towns in a National League of Cities survey overwhelmingly confirmed (89%) that violence in the schools was a problem in their communities (Arndt, 1994). Nearly one in five children in Washington D.C. reports being victimized (Richters & Martinez, 1993), but youth violence against youth is far from just a big city problem. Rural, suburban, and city students report similar problems that result in young people's concerns of peer on peer abuse. Studies from even the safest, small-town environments find that more than three out of four students report being bullied by their peers (81% of males and 72% of females) (Hazler, Hoover, & Oliver, 1991). Youth anxieties surrounding the dangers they face from their peers are clearly problems seen and experienced by the vast majority of our youth.

Peer on peer abuse cuts across a variety of places, situations, and types of people. Forty percent of teenage women report being the victim of violence in standard dating relationships (Burcky, Reuterman, & Kopsky, 1988). Schools are traditionally expected to be safe havens for youth, but each month over 1/4 million students report being physically attacked in school and one in five high school students avoid the school restroom out of anxiety about safety (Learning Publications Inc., 1988).

A comparison of 1940 and 1990 teacher impressions of what constituted their *top disciplinary problems* clearly highlights the difference in school environments. Teachers in 1940 reported their major problems as dealing with talking out of turn, chewing gum, making noise, running in the halls, and cutting in line. This is a far cry from 1990 where teachers expressed their struggles with assault, robbery, drug abuse, pregnancy, and suicide (Toch, 1993).

Even the school playground area that is designed for relaxation and reduction of tension, does not seem to get the job done. A video camera positioned to view a Toronto school's playground saw over 400 episodes of physical bullying during a 52 hour period (Marano, 1995). These numbers take on even more significance when you consider that the most common forms of bullying are ridicule, verbal, and social harassment (Hoover, Oliver, & Hazler, 1992) which would not even be generally caught by the camera.

It is clear that we have a problem with the violence surrounding our young people and that our traditional ways of dealing with those problems have not been working. The situation is not getting better, instead it is getting worse.

Our responses to peer on peer abuse seem to put the greatest amount of confidence and effort into tactics revolving around adult supervision, threat of punishment, and actual punishment of offenders. These additional policing actions including adult supervision, metal detectors, locks on doors, stiffer regulations, and harsher punishments appear to have some positive short-range effects. On the other hand, the short-range and long-range trends of increasing youth violence are not being halted by these measures.

The failure of additional adult control measures to have the large-scale impact we desire calls on us to seek additional resources. This article addresses one of those other resources: "The rest of the kids - the bystanders." The largest group of people who are often ignored in actions taken to stem youth violence are the bystanders who recognize what is happening yet do not know enough about their roles, emotional reactions, and responsibilities to take viable actions.

Most responses to violence seek to take three general paths to prevention, intervention, and remediation: 1) Set up rules and regulations to be followed, 2) Catch, try, and punish the offenders, and 3) Provide support for the victims. It is a model that has merit for focusing on the people most directly involved (abusers and victims), for protecting others from direct involvement, and for teaching problem youth to deal with aggression through rewards and punishments (Hoover & Oliver, 1996). Its weakness is that it ignores both the impact of bystanders' awareness of violence and their potential to productively influence current and future situations. There is little research on youthful bystanders, but there is enough general information to get started on efforts to better understand and utilize this group in the fight against youth violence.

Who are bystanders?

Bystanders come in all ages, shapes, colors, and sizes. While they normally make up the majority in any given situation, they do not naturally make use of the potential influence their majority status offers. The highly respected Senator and Vice President, Hubert Humphrey, put this inability of bystanders to act on their potential influence on an international scale in the following way: "Today we know that World War II began not in 1939 or 1941 but in the 1920's and 1930's when those who should have known better persuaded themselves that they were not their brother's keeper." (Speech given November 11, 1965 at the Arlington Memorial Cemetery, Washington, D.C.) The problems were known and much of the world chose to stay out of them mostly because bystander countries did not know how to react or were fearful of the consequences of their actions.

Humphrey called our attention to a world class of bystanders while the experience of Kitty Genovese shocked New York and much of our country into grappling with similar issues in a more personalized way. Her desperate cries as she was stabbed repeatedly in the street did not bring any help from her 38 neighbors who heard those cries (*Chicago Times*, 1995). Similar situations regularly bring the issues of bystanders, their actions, and their responsibilities to our consciousness: The barroom rape in New Bedford watched by a full house of patrons (Clendinen, 1983), fifteen young bystanders corralling Deborah Williams in Oakland where she was then stabbed and killed by her attacker (Warren, 1993), or the onlookers on a Detroit bridge who watched a young woman be beaten until she eventually jumped to her death (*USA Today*, 1996). We feel the pain of the victims, we are angered at the attacker, but our identification with the impotent behaviors of the bystanders may be the most troubling aspect of all.

Much of my recent research and writing has been with school bullying, peer victimization, and the rest of the students in school who find themselves in situations with many similarities to adult life and death situations (Hazler, 1996; Hazler & Hoover, 1996; Oliver, Hazler, & Hoover, 1994; Hazler, Hoover, & Oliver, 1993). Bystanders are the most overlooked group when attention is finally given to a school problem involving bullying, crime, or violence. Professionals, parents, and friends understand that they need to pay attention to the victims, because they accurately see them as receiving the brunt of a hurtful situation. The bully or criminal gets attention because our society demands punishment of those who harm others wrongfully. Less often, some will recognize that bullies need therapeutic interventions as well to provide them with more appropriate ways of interacting with others for the betterment of everyone. Bystanders are the largest group and get by far the least attention even though the impact of the events on them creates serious problems.

At the most instantaneous level, we know that victims and bystanders have similar physiological arousal reactions (Hosch & Bothwell, 1990). These basic similar reactions appear to be followed by other commonalties of development for the two groups. For example, those victims and bystanders who live with violence over time begin to repress their feelings of empathy for others (Gilligan, 1991). Replacing the idea of exposure to violence with the seemingly lower impact of general negative behaviors in school, we find that school children also become increasingly desensitized to negative behaviors which continue as they spend more time in the presence of these situations (Safran & Safran, 1985).

The loss of sensitivity by those who witness violence and negative behaviors certainly has problematic learning implications. Academically, we know that children who must ward off fears have more difficulty in school (Craig, 1992). Logic and research tends to support this idea that less sensitivity and less empathy for others must hurt relationships and other forms of development. This progressive loss of connection with others may be the reason that one study found 54% of middle/junior children in Sheffield, England had reported trying to help someone being bullied, while only 34% of more experienced secondary students would similarly try to help (Whitney & Smith, 1991). Perhaps we can follow this desensitization pattern into adulthood where another study found that only one in four adults (25%) witnessing a public child abuse event made any attempt to intervene (Christy & Voigt, 1994).

It is hard on a person's self-respect and self-confidence to see someone get hurt and know that you have done nothing to stop it. Bystanders generally remain on the sidelines for one of several basic reasons:

1. They don't know what it is they should do,

2. They are fearful of becoming the brunt of the bullies' attacks, or

3. They might do the wrong thing that could cause even more problems. (Hazler, 1996). Any normal person's level of anxiety is raised when they enter the middle of a conflict situation where the questions of who is right, who is wrong, and whether you can gain the upper hand are unanswered. The emotionally safest route and most common route taken is the avoidance of getting involved.

Avoiding direct involvement in confrontations reduces the potential for obvious failure, but at the same time it gives bystanders a feeling of powerlessness, similar in some ways to that of victims. Victims know everyone was watching their victimization and that a loss of everyone's respect is probable because their impotence was so obvious. The negative consequences for bystanders are more subtle and unexpected. Their own loss of self-respect and the fear that others might recognize their failure to act is not as obvious as those most directly involved. Keeping out of the situation is the way that bystanders control their potential for failure in the eyes of others, but they still forfeit a significant part of their own self-respect. An adrenalin rush may well come with watching someone be victimized, but there is no pride or self-respect in knowing you are an ineffective bystander in someone else's traumatic situation. Regaining the self-respect and confidence that goes with feeling in control does not have to come by accident. It can also be conscientiously fostered by counselors, educators, and parents.

Helping bystanders gain control

Identifying ways to help bystanders make the best of their situation focuses most commonly on group training activities. Feelings of isolation and ineffectiveness are commonly held by individual bystanders, while as a group they have the opportunity to gain and realize strength in community. Group teaching, counseling, and training activities help students to recognize the commonality of feelings, concerns, and even the empowerment that comes from a unity of purpose and recognition of available support for individual actions. Producing these conditions is important for the social and psychological well-being of the individuals involved, and also for creating the type of environment that condemns abuse and knows how to intervene when people are being abused.

The following are general guidelines for teaching young people to be stronger, more capable, and more confident in their ability to intervene and/or provide effective support during conflict situations. Each of the guidelines places primary attention on acquiring acceptance and understanding of one's own feelings and abilities, while at the same time empathizing with other bystanders, victims, and perpetrators.

Recognize feelings and discomfort and give permission to act on them

Bystanders tend to feel afraid, embarrassed, and inadequate about their non-response or ineffective response to the abuses they observe. Most want things to be different and they desire to help. Positive motivations have probably moved them to try some interventions in the past which have had little effect and possibly even brought the wrath of others down on themselves. What bystanders need first is to recognize their troubled feelings, see that they are not alone, and be given permission to act on their feelings of discomfort even when they are not sure of exactly what is best to do.

Any number of group awareness building activities can be used to encourage this first step towards public recognition and acceptance of one's awkward position. This lays the groundwork for bystanders to get off the sidelines by giving them permission as individuals to openly question what is happening and to get involved. These students need to recognize that significant strength comes from recognizing they are not alone in either their anxieties or their potential for positive actions. Support is available in the form of their peers and even adults who are reacting similarly to their own troubling situations.

Decide on specific actions to take

There are better and worse actions for bystanders to take, but any action that helps in any way will benefit everyone. The worst way to promote future effective action taking is to take no action. Ineffective or inappropriate actions can be revised and so lead to better designed actions in the future. We can learn from attempts that don't work better than we learn from taking no action.

Bystander feelings of inadequacy tend to originate from inaction more than from wrong actions. Reversing this trend toward inaction is critical to improving bystanders' feelings about themselves and their ability to affect their environment. Adults do not need to provide a "Top Ten" list of ways to interact during difficult situations. Young people in groups come up with numerous good ideas on how to improve their reactions to others. What they need is to be given the encouragement and opportunity to come together, share, practice, and evaluate their actions in the presence of adults who know how to foster positive ideas.

Provide direct and indirect support for victims

Bystanders can get involved by helping victims either through direct intervention or personal support. Individual bystanders with enough power, skill, or influence may be able to change the problem situation for the victim by direct intervention, but that is not always the case. The larger the numbers of bystanders available and the more united they are in their approach, the greater will be the possibility for direct, power-based intervention being successful. Students should give considerable discussion to the possible direct means of intervention, potential consequences, and ways to make the best out of a situation where things go wrong.

A less direct and less risky alternative is to find ways outside the immediate conflict situation to be available, understanding, and supportive of victims. Individuals can often provide this form of support better than groups because of the greater opportunity for privacy and less embarrassment for victims. The individual approach is easier to employ when unity among bystanders is not high, or when one is not present at the conflict situations.

The bystander's anxiety and the victim's embarrassment can make it difficult to recognize methods and times to give individual support to victims. The resulting feelings of inadequacy push victims and bystanders towards the worst possible practice of isolating themselves from others. Once the tendency to isolate oneself can be overcome, the following ways to give support to victims can emerge:

- Spend time with victims,
- Get physically and personally closer to victims rather than keeping your distance,
- Talk with victims about casual things,
- Invite victims to be involved in a variety of group activities,
- Be encouraging of victim efforts and accomplishments,
- Talk about serious things and problems when the victim wants,
- Express a desire to find additional ways to help, and
- Give support regularly (once doesn't do it).

Constructive interaction with abusers

Bystanders will have a wide variety of conflicting feelings about abusers including the common ones of fear and dislike along with the less expected feelings of liking the person in other situations. This confusion of feelings about abusers is common, reality based, and can be a valuable tool for helping improve the situation. The mixed feelings provide an opportunity to treat abusers, not as pariahs to be damned and avoided, but instead as human beings who can be encouraged to give energies to their more positive qualities.

Abuse is wrong and concerned bystanders must denounce it. However, they need to focus their attention on the abusive behavior and not the person who is the abuser. "What you did to that girl stinks!," is a valuable denunciation of the action. "That was terrible! You are a jerk!," is a personal attack that could make things worse. Young people need to know that denunciations of an action can be followed by feelings of liking and concern also, "That's not like you."

Students can be more effective when they learn to discuss the problem behavior with abusers rather than simply demean them as bad people. The abuser's positive aspects need support and attention as much as the negative aspects need condemnation. Bystanders can offer that support in ways that are much less potentially volatile than condemnation and intervention from adults. This makes these efforts potentially useful by everyone and not just the most confident and able of bystanders.

Seek help in appropriate ways and situations

It is a truism that, "Everyone needs help from time to time and you have the right to ask for it when it is needed." Bystanders need to know when and how to ask for that help from peers and adults.

Somewhere between "I'm anxious" and "only when a disaster has occurred" are located the appropriate places to seek assistance. Asking for assistance too early and too frequently stunts people's ability to learn their full potential for dealing with difficult situations. There will not always be someone else there to fix things so requests for help should be sought only after other alternatives have been considered and in most cases tried.

Well written and agreed upon school or home rules provide additional guidance on when, where, and how to seek the intervention of peers and adults. These rules let young people know when actions are not appropriate to be reported and when they are. Rules that are then actively and consistently supported by adults create a bond of trust and confidence that makes both groups stronger than either could be separately.

Giving voice to the silent majority

The majority of people associated with peer on peer abuse are bystanders and not obvious abusers or victims. Those who watch, avert their eyes, pretend not to notice, egg on protagonists, stand on the outskirts, and provide an audience are all too often the silent majority. They often feel they have no voice or insufficient knowledge about how, when, or where to speak up or take action. Their doubts and confusion can immobilize their potential power so that they hope against hope for someone else to come and fix the problem. They fail to recognize that they are the someone elses of both the youth and adult worlds.

Abusers require the isolation of their victims in order to maintain a continuing abusive imbalance of power, but isolation does not mean in the absence of others. Victims are isolated in public all the time when bystanders choose to allow abuse to go unattended. When bystanders can find and make use of their individual and collective voices, they do make a difference.

Specific programs and activities to help bystanders find their voices are available in every school district right now. We often look for the most current published information, programs, and activities designed specifically to stop peer on peer abuse in the schools (Hazler, 1996; Hoover & Oliver, 1996; Garrity, Jens, Porter, Sager & Short-Camille, 1994; Shephens, 1995). These materials are effective, but many of the same core ingredients including: empathy development, communication skills, decision-making processes, assertiveness, responsibility, and self-control are also available in other materials under the subject categories of conflict-resolution, peer mediation, substance abuse prevention, social skills training, and interpersonal skills development. Between these general groups of materials every school and agency should have ample access to materials necessary to make a competent start in providing the silent majority with the information and skills they need to find their voices.

What every professional and parent must remember is that the silent majority got that name because they are quiet, do not make waves, and are not often heard. They are not the ones with the bloody noses or carrying a knife so they will not automatically gain our attention. We must go out of our way to notice them, attend to them, listen to their struggles, realize their significance, and make use of their potential. If we start early enough in their youth, we may just be able to create the more involved next generation of adults that would make us proud.

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The Relationship Between Esophageal Speech Acquisition and Self-Concept Following Total Laryngectomy

Dianne C.Slavin

Joyce A. Rubenstein

This study investigated the relationship between self-concept and esophageal speech acquisition. Fifty laryngectomized patients completed the Tennessee Self-Concept (TSCS) at the initiation of speech therapy and again four months later. Esophageal speech proficiency ratings were correlated with TSCS scores pre- and post-speech therapy. No statistically significant changes in the TSCS scores were demonstrated following speech therapy. Results are discussed in regard to the importance of esophageal speech acquisition to the rehabilitation process and the counseling needs of this population.

A diagnosis of cancer is traumatizing for a number of reasons including fear of death, isolation, and physical disfigurement (Holland & Rowland, 1989; Welch-McCaffrey, Hoffman, Leigh, Loescher, & Meyskens, 1989). Persons surviving cancers of various types including laryngeal cancer have been reported to experience emotional reactions such as depression, anxiety, and denial (Bisi & Conley, 1965; Gates, Ryan, & Lauder, 1982; Holland & Rowland, 1989). These emotional reactions may be further intensified in persons with laryngeal cancer when their treatment includes a total laryngectomy. Gardner (1971) wrote that the laryngectomized person receives three blows to his or her well being: 1) the diagnosis of cancer, 2) the loss of voice and 3) physical change in the form of a tracheostoma. Laryngectomy has been described by Bisi and Conly (1965) as a mutilation that deprives the individual of functions necessary to adaptation. Voice, they maintained, is an important and central facet of identity fulfilling important social functions including communication with others, expression of emotions, situational control, defenses, gratification, and carrying out sublimation.

Counseling patients following laryngectomy would appear to be of obvious benefit to laryngectomized individuals to facilitate their adjustment to this acquired disability. Counseling is recommended for cancer patients for a number of reasons including isssues related to grief (Kissane,1994), anger (Faulkner, Maguire, & Regnard, 1994) and quality of life (Reele,1992). Yalom (1980) described how cancer patients may deal with thoughts of impending death by rearranging life's priorities and improving communication with loved ones. In the case of the laryngectomized, the loss of voice may impede their ability to cope by increasing their sense of isolation and helplessness. Through counseling, these issues could be addressed.

Despite the emotional trauma associated with laryngectomy, many patients do not receive counseling services. As hospital stays are limited in an effort to reduce health care costs, patients may well be discharged before counseling can be initiated. In a survey conducted by Salvall & Kallail (1989), they found that 40% of their 120 laryngectomized respondents reported never receiving any counseling.

It is often the speech-language pathologist (SLP) who, in the course of providing alaryngeal voice instruction, has the most frequent contact with these patients following surgery. The SLP attempts to facilitate post-surgical adjustment of laryngectomized patients by aiding in the acquisition of one or more of the three forms of alaryngeal speech: esophageal speech, tracheo-esophageal speech and/or speech by means of an artificial larynx.

Past research into the psychological components concomitant with a laryngectomy has shown a relationship between psychological factors and esophageal speech training. Early researchers (Faulkner, 1940; Greene, 1947; Diedrich & Youngstrom, 1966) found that emotions such as fear, insecurity, inadequacy, grief, anger, depression, and anxiety may affect the muscular control necessary for the development of esophageal speech. Additionally, Barton & Hejina (1963), Shames, Matthews and Fort (1963), and DiBartolo (1969) found that personality characteristics including mental ability, motivation, overall personality adjustment, personal worth, self-reliance and self-concept were generally better in esophageal speakers who acquired good speech than in esophageal speakers who did not acquire good speech. However, the more recent work of Blake (1974) and Blood, Luther & Stemple (1992) fails to substantiate these findings.

Blood et al. (1992) surveyed 41 patients with laryngectomies to assess how well these patients adjusted to and coped with cancer, and to determine whether or not adjustment was related to the type of alaryngeal voice they used and/or to the length of time since the laryngectomy. They found that the mode of verbal communication was unrelated to overall adjustment to the disability and that approximately two thirds of their subjects did adjust well over time. Interestingly, the subjects who were better adjusted reportedly viewed their rehabilitation more positively and also viewed themselves as better communicators than the subjects who were less well adjusted.

Blake (1974) attempted to evaluate specifically the relationship between esophageal speech learning and personality traits over time. This study concerned itself with measurement of the specific personality traits present at the beginning of alaryngeal speech therapy and four months later, using the Minnesota Multiphasic Personality Inventory (MMPI). Blake sought to identify personality characteristics related to esophageal speech development, as well as to describe changes in personality as this alternative mode of speaking was acquired. Prior to beginning alaryngeal speech therapy, factors such as schizophreniam, hypocrondrasis, social introversion, and depression measured by the MMPI were found to be inversely related to alaryngeal speech proficiency. However, no significant changes in pre- or post-test personality traits were determined over the four month period. One explanation for the findings obtained in this study was that the MMPI may not have been the most appropriate tool for assessing personality traits in a population suffering from an organic etiology. The purpose of the Blake (1974) study was not to assess pathological deviancy nor to categorize patients, but rather to examine personality characteristics in a more detailed and refined manner. Since assessment of pathological deviancy and categorization of psychopathology are the primary functions of the MMPI, instruments other than the MMPI may have been more adequate for characterizing personality characteristics and changes in the laryngectomized patient.

A more fruitful area of investigation may be to examine self-concept as it relates to the attainment of esophageal speech. DiBartolo (1969) studied the relationship between self concept and anxiety to esophageal speech proficiency by administering the Tennessee Self-Concept Scale (Fitts,1965), the IPAT Anxiety Scale and a tape recorded, standardized personal interview to 96 laryngectomized patients. DiBartolo correlated self concept characteristics and anxiety levels of his better esophageal speakers to those of the poorer esophageal speakers and found that better esophageal speakers had higher self-concept, higher body-concept and less anxiety than the poorer speakers he studied. However, he did not look for a possible positive change in self-concept as esophageal speech became a functional means of oral communication.

The purpose of the present study was to further investigate the relationship of esophageal speech development to self-concept. While Blood et al. (1992) have shown that many laryngectomized persons adjusted well over time, approximately one third of their subjects did not. By determining the relative value of speech reacquisition to the adjustment process following total laryngectomy, speech-language pathologists and mental health counselors would be aided in weighing the importance of recommendations for psychological support for this population. The following questions were posed: Is there a relationship between self-concept as assessed at the initiation of speech therapy and the degree of success in acquiring esophageal speech four months later? Is there a relationship between degree of success in achieving esophageal speech following four months of speech therapy and change in self-concept over that four month period?

Method

Subjects

The 50 laryngectomized subjects in the study were chosen based on the following criteria: (a) total laryngectomy with or without a radical neck dissection, (b) laryngectomy within three months prior to the initial evaluation, (c) age range of 35 to 70 years, (d) no esophageal speech training prior to initial evaluation, (e) acceptable health for initiation of speech therapy as determined by physician, (f) no gross structural abnormalities other than the laryngectomy as determined from the medical record, (g) essentially normal oral peripheral examination with minor deviance noted, (h) inability to consistently produce esophageal speech upon initial evaluation, (I) speech reception thresholds of 25dB or less in at least one ear as determined by a licensed audiologist, (j) sixth grade reading level as determined by the Comprehension Subtest of the Gates-MacGinitie Reading Test (Gates & MacGinitie, 1965). There were 35 males and 15 females between the ages of 35 and 70. All attended The Brooklyn Hospital Speech and Hearing Center for testing and therapy. Due to the sudden onset and seriousness of this communication disorder, laryngectomized patients were given the highest priority for treatment. Withholding speech therapy for the four month period of this study was considered to be unethical; therefore, no control group was formed.

Self-Concept Measurement

The Tennessee Self-Concept Scale (TSCS) (Fitts, 1965) was used to assess self-concept at the initiation of esophageal speech therapy and again four months later. The TSCS consists of 100 self-descriptive statements which individuals use to portray their own picture of themselves. The individuals indicate on a five point scale if each statement is completely true, mostly true, partially true, partially false, mostly false, or completely false. It was designed to meet the needs of subjects from healthy and well-adjusted to psychotic.

The dimensions of the TSCS include five aspects of self (physical, moral-ethical, personal, family and social self), and the dynamics associated with each of these. The physical self is subdivided into identity, self satisfaction and behavior. The physical self refers to how individuals view their body, state of health, physical appearance, skills, and sexuality. The moral-ethical self refers to moral worth, feelings of being a "good" or 'bad" person, and satisfaction with one's religion or lack of it. The personal self reflects the individual's sense of personal worth, his adequacy as a person, a personality apart from the body, and relationships to others. The family self reflects one's feelings of adequacy, worth, and value as a family member; in reference to close and most immediate circle of associates. The social self is the self as perceived by others in a more general way than the family self. It reflects the person's sense of adequacy and worth in his social interaction with other people in general (Fitts, 1965). The subscores of the TSCS differentiate normal and psychiatric groups as well as different types and degrees of disorders.

The TSCS has proven useful in detecting changes in self-concept that result from participation in a variety of programs designed to change behavior (Biase & Sullivan, 1992; Rogers & Alexander, 1990). Other investigators have used this measure to study the effect of psychotherapy and other positive and negative experiences as they affect self-concept (Ashcraft & Fitts, 1964; Bryan, 1974; Giuiden, 1959).

Procedure

At the initial session, a detailed case history, an audiological screening and a reading screening were obtained for each subject. The first measurement of self-concept using the TSCS was also obtained following standard administration procedures as presented in the manual (Fitts, 1965). Following this session, subjects were placed on a program of standard esophageal speech therapy as described by Keith & Darley (1986) and Salmon & Mount (1991). All subjects received esophageal speech therapy three half-hours per week for four months. Speech therapy was administered by New York State licensed speech-language pathologists with a minimum of two years experience in esophageal speech therapy. A four month time period was chosen because the authors of the present study, and others, have observed that on the average most laryngectomized persons will acquire some degree of esophageal speech within four months (Lauder, 1976). In addition, Blake (1974) found that laryngectomized people who discontinued speech therapy before four months had significantly higher depression and hysteria. During the therapy program, a log was kept documenting the patient's progress and setbacks.

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At the end of four months of esophageal speech therapy, a speech recording was made. The recorded sample consisted of an oral reading of the first paragraph of a phonetically balanced essay the "Rainbow Passage" (Fairbanks, 1960). The recording for each subject was made in a quiet room on an individual basis to insure a minimum amount of noise and distraction. Subjects were told that the recording was made to examine their esophageal speech capabilities. They were told to read the passage aloud one time for practice and once more for purpose of analysis.

The speech samples were recorded on Maxwell BD935-90 tape at 7 1/2 ips speech using an Akai 1722 II stereo tape recorder with a frequency response of 30-21,000 Hz. The sample was recorded through a Shure ribbon microphone model 330 with a 30-15,000 Hz frequency response. During the same session, the TSCS was readministered following standard testing procedures as described in the manual (Fitts, 1965).

Three SLPs who had no contact with the subjects prior to this study served as judges. The judges rated each of the speech samples twice on a seven point equal interval scale as designed by Robe, Moore, Andrews and Hollinger in 1956. The following were the possible ratings: (1) no intelligible esophageal speech produced, (2) partial control; single words under fair control, (3) simple words produced, (4) combines 3-4 words, (5) some sentences used, (6) sentences consistently used, and (7) fluent, non-hesitant speech.

Inter-judge reliability for the esophageal speech ratings for the three judges was .98905 ($\underline{p}$ <.05). Intra-judge reliability for each of the three judges on the two trials also indicated equally high reliability coefficients of .98657, .99064 and .99673 ($\underline{p}$ < .05).

TSCS Scoring procedures

TSCS total scores and subtest scores were calculated by adding the ratings indicated by the subject. Total scale scores can range from 100 to 500 with higher scores indicating a more positive self-concept. Scores were calculated for total score and five categorical scores: physical self, moral-ethical self, personal self, family self, and social self.

Results

Descriptive Analysis

Pre- and post-therapy TSCS values were scored as described above. Table 1 shows the mean pre- and post-therapy TSCS scores for the total sample. Review of these data reveals an improvement in each of the TSCS subscales.

Table 1

Means for Pre- and Post-therapy TSCS Scores for Total Population. (N=50)

Variable Name	Mean Pre-Therapy Score	Mean Post-Therapy Score
Total P Score	324.62	336.94
P Score–Identity	115.89	119.48
P Score–Self Satisfaction	102.26	106.28
P Score–Behavior	104.32	111.18
P Score–Physical Self	58.18	63.42
Moral-Ethical Self	65.76	71.18
Personal Self	51.24	65.46
Family Self	67.44	70.36
Social Self	62.86	66.32

Total scores for this group of the subjects placed between the 30th and the 50th percentiles both before and after four months of speech therapy. However, the group scores for P score—self-satisfaction subscale score, improved from below average before speech therapy to above average after speech therapy. Measures of the variable "physical self" were the lowest of all the variables assessed both pre- and post-therapy. Group scores for Moral-ethical Self, Personal Self, Family Self, and Social Self all were below average before treatment. The most improvement was seen in the total P score which, according to Fitts (1965), is the single most important score on the test reflecting overall level of self-esteem. At the end of four months of speech therapy, only scores related to social self remained in the below average range. Taken together, the profiles of the subjects in this study present self-concepts that deviate from the norm in several psychological dimensions regardless of their ability to master esophageal speech.

Statistical Analysis

In order to assess the relationship between the initial evaluation of self-concept and degree of esophageal speech proficiency four months later, speech ratings for the subjects were correlated with the total P score (total positive score) on the TSCS as well as with each of the sub-scores to find significant relationships using the Pearson correlation (Blalock, 1972).

The first hypothesis stated that there would be a positive relationship between initial self-concept and achievement of esophageal speech proficiency. However, no statistically significant correlation between the nine dimensions of self-concept assessed by the pre-therapy TSCS and esophageal speech proficiency for the 50 subjects was found.

The second hypothesis predicted a positive relationship between change in self-concept and degree of speech proficiency attained. That is, laryngectomees with a more positive change in self-concept would achieve higher speech ratings than those subjects with a less positive change. An analysis of covariance revealed no significant change in self-concept following the four month period of esophageal speech therapy for the group as a whole.

Discussion

The purpose of the present study was two-fold: to investigate 1) the relationship between self-concept as measured by the TSCS and the development of esophageal speech acquisition and 2) the relationship between esophageal speech proficiency and changes in self-concept. The mean total scores both before and after speech therapy failed to exceed the mean of the standardization group. These subjects also scored below average on subtests relating to moral worth, sense of personal worth, value as a family member and the self as perceived to others. These results support the notion that recently laryngectomized patients have lower self-concepts than the general population. This may be due, in part, to an altered self-image that had not yet been successfully integrated into their self-concept.

The P—identity sub-test, that shows how individuals see themselves in terms of "what I am," was also below average. The laryngectomized persons in this study presented with a weak and generally negative self-identity at the time they were examined. This result was not surprising when one considers the emotional trauma concomitant with the knowledge that one has cancer and must adjust life goals accordingly. The obliteration of vocal function must also influence how an individual feels about himself, an effect demonstrated in the low scores our subjects achieved on identity self-concept.

The results of the present study are in accord with those of Blake (1974) who reported no significant change in personality characteristics as measured by the MMPI following esophageal speech therapy. The lack of a significant relationship between self-concept and esophageal speech may be due to the complexity inherent in cancer rehabilitation. For example, the subjects who ultimately acquired better esophageal speech may have suffered from a strong negative reaction to their trauma and, as Blood et al. (1992) suggest, adjustment post laryngectomy may be a slow process that takes many months or even years. Blood et al. (1992) also conclude that self-esteem issues do not appear to be tied to communication competence in all cases. Some of their subjects failed to adjust well in spite of functional alaryngeal speech, while others reported good post-surgical adjustment dispite their inability to develop functional alaryngeal speech.

The findings of the present study are also congruent with the literature regarding the effects of counseling with cancer patients generally. Meyer (1995) applied a meta-analysis to 45 studies reporting 62 treatment-control comparisons. Meyer concluded that while counseling is considered to be beneficial to cancer patients, control comparisons did not significantly differ among several treatment categories possibly due to the low statistical power used in the evaluation of effects.

In regard to the present study, the relationship between esophageal speech acquisition and self esteem remains unclear. One explanation for the lack of significant findings may be that the effect of esophageal speech acquisition was not strong enough to overcome the traumatic impact of total laryngectomy on the individual's sense of well-being. For some patients, the loss of laryngeal voice may be the problem of primary concern. King, Fowlks, and Pierson (1968) reported that 50.8% of their laryngectomized subjects never used an alternative form of communication whether it be esophageal speech, artificial larynx speech or writing outside the home.

Given the TSCS profile scores of the 50 laryngectomized people who participated in this study, they might have benefited from psychological counseling had it been available to them. While the acquisition of alaryngeal voice is a vital part of the post-laryngectomy rehabilitation process, the need for psychological counseling should not be neglected for these patients. Laryngectomized patients must face the same fears as other cancer victims including fear of death, physical mutilation, and reactions of family and friends (Hermann & Carter, 1994). Additionally, they have the hardship of continuing life without the voice that they and others who know them have come to identify them by. The impact of this loss should not be under estimated regardless of the time that has lapsed since the surgery.

Further research is needed to assess the effects of psychological counseling on adjustment following laryngectomy. Since the relationship between alaryngeal speech development and self-concept has proven equivocal, the degree of psychological adjustment following laryngectomy must not be based on the success the patient has in acquiring esophageal speech. Counseling should be made available to all patients as a routine part of the rehabilitation process.

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“*Not failure, but low aim, is crime*”

–JAMES RUSSELL LOWELL, “FOR AN AUTOGRAPH”

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Children from Chemically Dependent Families: An Evaluative Study

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This study evaluated the effectiveness of Children Are People Support Groups, Inc. (CAPSG), a prevention program for children ages 5 to 12 from chemically dependent families. Participants were 64 former CAPSG group members who had attended at least one eight-week session seven, six, and five years ago. In addition, 64 junior high school students and 15 Alateen members were administered the same survey for comparison purposes. Former CAPSG group members indicated significantly less past experimentation with chemicals than both the junior high school students and Alateen individuals. Their current use of chemicals was also significantly less than the two comparison groups. These results support the proposition that CAPSG is effective in decreasing chemical experimentation and usage by children whose parents are substance abusers.

Prevention programs for children of substance abusers (COSAs) are rare, but the number is increasing. One such program that has been in existence since 1977 in Minneapolis/St. Paul, Minnesota is Children Are People Support Groups, Inc. (CAPSG). This nonprofit agency facilitates educational support groups for children ages 5 (kindergarten) to 12, living in families with parents or relatives who abuse chemicals (alcohol and/or other drugs).

These groups meet for eight week sessions four times during a year. Children learn about feelings, defenses, decision making, chemical dependency, families, and specialness. The focus is to teach these children that they neither caused the chemical dependency in their families nor could they change it; however, they could learn to care for themselves. Groups consist of an introductory sharing time, a topic introduction, a large group activity, a small group activity with emphasis on personal goals, and a closing.

Although pre and post evaluations are given to assess the children's knowledge of the CAPSG curriculum, no research has been performed in order to study the long-term effectiveness of these groups on intergenerational chemical use. This evaluative research is an attempt to document the effectiveness of CAPSG's prevention program for COSAs.

Review of the Literature

Nearly seven million children are COSAs (Bellin & Hammerslough, 1992). While many children from chemically dependent homes do not become substance abusers themselves, the likelihood that they will is increased due to living in an environment where such abuse is considered "normal." The Office for Substance Abuse Prevention (1990) estimates 12-25% of COSAs will develop substance abuse problems.

Besides the increased risk of developing an addiction to chemicals, COSAs have a higher incidence of emotional problems such as anxiety, depression, and limited coping skills. They also have a higher incidence of school problems, difficulty concentrating, and truancy than children from chemically free families (Buwick, Martin, & Martin, 1988; Stern, Kendall, & Eberhard, 1991; Van Den Bergh, Hennigan, & Hennigan, 1989).

COSAs have difficulty in identifying and expressing feelings. They have learned to deny their feelings because they are unable to tolerate their strong reactions to the family situations; that is, COSAs protect themselves with denial (Black, 1982; Lawson, Peterson, & Lawson, 1983). A majority of these children have decreased self-esteem, possess an external locus of control, and believe they receive less than normal amounts of affection (Black, 1982; Wood, 1992). These factors can lead to impaired gender and sex role development, as well as impaired social relationships. Data indicates that many COSAs suffer emotional problems and adjustment difficulties that are a direct result of the daily interactions with their substance abusing parents (Buwick et al., 1988).

Chemically dependent family systems are often multiproblem families with considerable stress in their environments. The strains derive from the absence of healthy life skills, including inadequate family management techniques such as disorganized households, few rules, inconsistent discipline, and decreased childhood supervision (Kumpfer & DeMarsh, 1985). Lack of family stability is also present, due to frequent moves, divorce, death, prison terms, and decreased family rituals (Johnson & Montgomery, 1989; Kumpfer & DeMarsh, 1985; Mackensen & Cottone, 1992).

Studies consistently find COSAs at risk of serious medical and psychological problems such as fetal alcohol syndrome, learning disabilities, suicide, eating disorders, psychosomatic illnesses (i.e., headaches, stomachaches), and compulsive achieving. Many COSAs endure physical, emotional, and sexual abuse or neglect at home also (Office for Substance Abuse Prevention, 1990; Van Den Bergh et al., 1989).

It is clear from the predominance of risk factors that these children are more vulnerable to alcohol and other drug abuse than the general population. It is not only imperative that prevention programs target COSAs, but they also must identify such children early and deliver services before substance abuse, emotional, and/or behavioral problems develop in the lives of these children (Pilat & Jones, 1984/85).

Method

Participants

The participants included 64 former CAPSG group members who had attended at least one eight-week session when they were between the ages of 5 and 12 years. Their ages now ranged from 10 to 20 years. Their recruitment had been achieved through a random selection process of old CAPSG records from seven, six, and five years ago. (The researcher is a CAPSG facilitator and, therefore, had access to confidential files.) Eighty-six former group members were mailed a cover letter and a four page questionnaire, which 45 individuals returned. An additional 19 participants chose to be interviewed over the phone. Of the 105 people contacted for participation in this study, 64 participants responded (61%). The questionnaire included the Generalized Contentment Scale (GCS) and questions related to various behavior response patterns including prior and current chemical use. Since this GCS is not relevant to the hypotheses of the current report, it will not be commented on further.

A revised questionnaire, which was identical to the original survey except it omitted specific questions regarding CAPSG experiences, was given to 15 COSAs who had not received CAPSG services; namely, members of Alateen. Their ages ranged from 13 to 19 years.

Sixty-four junior high school students also completed the revised questionnaire. This group was added in order to evaluate where average teenagers (13-15 years old) would fall in comparison to the children who were known to live in substance abusing households. All three groups contained a total of 64 males and 79 females.

Data Analysis

The surveys were hand scored by the researcher, and the data was reported in the form of percentages. The percentages reflect those subjects surveyed who responded to a question in a particular response category. The percentages derived in the tables were rounded to the nearest whole number. A two-way classification chi square (χ^2) was used to analyze differences between the three groups regarding their prior and current chemical use.

Results

There was a significant difference in the past experimentation with chemicals for the three groups; rather, former CAPSG subjects had experimented with substances less than both the junior high school students and the Alateen members (Table 1).

Table 1
Group Member Type and Past
Experimentation with Chemicals

	Experimentation	
Group member type	**Yes**	**No**
CAPSG	28% (18)	72% (46)
Junior high school	50% (32)	50% (32)
Alateen	73% (11)	27% (4)

χ^2= 13.12.$\chi^2_{.05}$, df = 2, is 5.99. Significant, $p < .05$

Note. n = 143.

There was also a significant difference in the current chemical use by the subjects. The former CAPSG members reported less current use of chemicals than the other two populations surveyed (Table 2).

The former CAPSG group members were also asked a direct question of whether or not they felt they had benefitted from attending CAPSG's prevention program. Sixty-six percent of the individuals responded positively. Comments of participants regarding benefits of the program remarked that it was nice "to know that there were other people with similar problems," "to have a high self-esteem," "to discover hidden feelings," "to talk to other people about problems," "to find out that more people care," "to find that

Table 2
Group Member Type and Current
Chemical Use

Group member type	Current Use Yes	No
CAPSG	13% (8)	87% (56)
Junior high school	16% (10)	84% (54)
Alateen	47% (7)	53% (8)

$\chi^2 = 8.23. \chi^2_{.05}$, df = 2, is 5.99. Significant, $p < .05$

Note. n = 143.

alcoholism in a family is no one's fault," and "to feel better about life afterwards." Other comments simply illustrated enjoyment of the group that participants wished to continue attending, and that attending was fun.

Discussion

The results of this study suggest that prevention efforts such as the CAPSG program are effective in decreasing experimentation and current chemical use of COSAs over time. By providing direct treatment services to offspring of substance abusers (e.g., group, family, and individual therapy) as well as education on chemical dependency, chemical dependency programs can make significant contributions to the fields of child welfare and addictionology, which ultimately would reduce the risks of being a COSA (Van Den Bergh, et al., 1989).

This study's findings, as noted from participants' comments, agreed with others. They have all found that COSAs need a forum to talk about problems, express feelings, know that chemical dependency is not their fault, and feel safe (Black, 1982; Wood, 1992). Prevention programs also appear to eliminate these covert effects of living in a chemically dependent home environment.

This study was valuable from the standpoint of being one of the first studies to evaluate the long-term effectiveness of a prevention program specifically for COSAs. Future research should increase the number of Alateen members studied. It is also recommended that prevention programs administer questionnaires that may be used as a baseline for continued follow-up over time to their participants. Childhood prevention programs cannot test long-term outcomes at this point, due to the lack of cross-sectional and longitudinal studies of COSAs (Kumpfer & DeMarsh, 1985; Pilat & Jones, 1984/85).

In summary, because COSAs appear to be at substantially higher risk for substance abuse, prevention programs must target them if they plan to significantly impact the multigenerational problem of chemical dependency. More educational support groups such as those offered by CAPSG are needed to build life skills and provide chemical health information for COSAs, in order to successfully break the cycle of substance abuse.

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Fairy Tales and Symbols: Gaining Access to the Unconscious

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The fairy tale when told in the aural tradition arouses archetypal images in the unconscious. To extend the previous work done by V. Walker and M. E. Lunz (1976), one storyteller told a fairy tale to a sample of 65 children who varied in age, cultural background, race and gender. After the telling of the tale, the children drew the picture that came to their minds as they listened to the story. The results indicate that each picture represented one or more archetypes, and multiple symbols appeared in the pictures 66% of the time. This study supports Jung's premise that utilizing fairy tales to stimulate images in the unconscious teaches the child at an early age to pay attention to inner processes. This study also has implications for the importance of training individuals who work with children to develop story telling skills.

Children of the latter part of the twentieth century require increasingly effective strategies to combat violence and confusion in our society. Educators and parents have inherited the challenge of teaching children how to develop quality relationships with themselves and with others. Enhancing a young child's ability to pay attention to inner processes is reported to aid in the development of values, morals and spirituality of the individual. Jungian psychology professes that the fairy tale is an ideal tool in accomplishing these developmental tasks as well as in combating psychic wounds and arousing resistance against difficulties in life. The first step in the process requires the establishing of a link between the conscious and the unconscious. Selected material from the unconscious can then be used for development and growth of the Self, thereby helping to avoid neurosis.

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Historical Perspective

Carl G. Jung was a close associate of Sigmund Freud, until 1913 when, because of differing beliefs, Jung founded a separate school of analytical psychology. Jung's new psychology was the psychology of growth, a psychology of the individual moving through various stages of psychic development, and of integrating internal opposites. The primary goal became the attainment of wholeness for each individual (Copeland, 1990). Jung believed that having a working relationship with the unconscious was essential to reach wholeness. The unconscious may be defined as the sum of all thoughts, feelings, and desires of which the individual is not conscious, or which have been repressed, but which influences the individual's behavior. Since the language of the unconscious is in symbol form, an understanding of the symbolic is also necessary (Copeland, 1993).

Jung (1944/1968 & 1955/1970) described the Self and its symbols as being that part of each individual which is unique and which contains a spark of the Divine. According to Jung, the Self encompassed and stretched beyond the entity commonly referred to as soul to include a respect for all creation. Jung believed that symbol production of the unconscious represented the psyche's attempt to grow and heal itself (Jung 1951/1959). To Jung, the images and symbols of the unconscious were valid, and when an individual related to these symbols and images in a personal manner, his or her inner life would unfold and develop. Gaining access to the unconscious and to its unique language of symbols can be accomplished through the telling and retelling of fairy tales and myths, thereby creating the link between the conscious and the unconscious. This link is particularly significant because the potential for dissociation lies in the separation of these two psychic spheres (Jung, 1938/1969).

Bruno Bettleheim (1977), educator and counselor of severely disturbed children, concurred with Jung that the use of fairy tales with children helped to heal psychic wounds and to restore meaning to the lives of children. The fairy tale reaches the inner person and speaks personally to the individual who experiences isolation or adversity. Fairy tales impart the general message that life's struggles, though unavoidable, can be overcome with persistence. Courage and hope are evoked in the listener of the fairy tale.

Jung placed great importance on special symbols which he termed "archetypes." Archetypes are interrelated symbols of unconscious psychic processes relating to the development of the Self. These archetypes or symbols are presented as images in the story. Webster (1983) defines an archetype as "the original pattern, or model, from which all other things of the same kind are made; prototype" (p. 97). Jung placed specific emphasis on the archetype. He used the word to designate those universal symbols that exhibit the greatest sameness across cultures. They also show the most potential for continued evolution and suggest a superior, higher meaning (Cirlot, 1971). The archetype is a thought form or a collective memory of experiences residing in the collective unconscious that people have shared since prehistoric times. According to Jung, while archetypes are not mental images in and of themselves, they do produce typical mental images. In other words, the word *archetype* refers to the tendency to form such representations. Archetypal images could vary greatly without losing their basic pattern (Jung, Franz, Henderson, Jacobi, & Jaffe, 1964). In fact, an archetype may manifest itself in a dual nature such as positive/negative or masculine/feminine. Two of the most powerful archetypal figures to be found in the unconscious are the animus and anima, which represent the inner personality of the individual. Consequently, a woman has a masculine soul, the animus, which emphasizes the principles of separation, discrimination, clarity and understanding, and a man has a feminine soul, the anima, which emphasizes the principles of merging, blending, and relationship (Copeland, 1993). Jung believed that individuals could grow and become whole by investigating and interpreting archetypal images through active associations using active imagination and art (McCullough, 1993).

Von Franz (1978), a noted Jungian authority on fairy tales, referred to fairy tales as being the purest, most valuable expression of the collective unconscious. According to Von Franz, archetypal images in fairy tales mirror basic patterns of the psyche more clearly than in myths or legends which contain an overlay of cultural material. Since multiculturalism is an important educational goal today, the fairy tale, being relatively free of specific cultural contamination, carries great importance. The fairy tale speaks to a deeper level of human experience where all basic patterns of behavior are held in common.

Current interest in the education of children focuses upon the reading experience with written response to literature; however, telling fairy tales rather than reading them emphasizes the feeling level as opposed to the cognitive level of experience. Clarissa Pinkola Estés (1992), a senior Jungian analyst and current popular storyteller and author, describes the telling of tales as a healing art whereby the storyteller handles archetypal energy that changes the individual. She believes that passing along a story is a large responsibility.

The focus in telling fairy tales is on imagination and problem solving as opposed to the literary experience of grammar, sentence structure, and action. When a story is read, the unconscious and its symbolic language are not aroused. In contrast, the recounting of fairy tales makes a connection with each listener, and each listener attunes himself or herself to the image which mirrors the unconscious developmental task in which he or she is engaged (Walker & Lunz, 1976). Fairy tales, when told, enable the storyteller to connect with the listener in a way that allows the symbology of the tale to arise in the mind of the listener. Because the language of the Self is that of pictures, images, metaphors and feelings, listening to fairy tales encourages school children to draw pictures, paint, and make clay sculptures. Jung speaks repeatedly in his Collected Works of the importance of art as an expression of personal experience as well as a communication which brings to life the unconscious processes of others. Since the amount of emotional and symbolic material a child shares is often dependent on the sensitivity and skill of the adult, it is important for teachers, counselors and parents to acquire skills to tell fairy tales in ways which encourage children to experience the symbology. In addition, it is important to train professionals in communication skills, allowing them to understand the emotional and symbolic expressions of children (Allan, 1988).

Purpose

The purpose of this study was to test the use of a fairy tale as a tool to engender unconscious symbology and archetypal images in school age children. The avenue of expression used was drawings done with crayons, pencils or markers. Because the fairy tale was told rather than read, it was anticipated that the drawings of children from diverse groups would contain visible archetypal images suggested by the total fairy tale and would not be illustrations of the action of the story. By hearing the tale, the children were expected to experience the tale as a whole rather than as separate units of action brought about by a reading experience. Since the aural form of expression appeals to both one's personal experience as well as to the experiences all human beings have in common, the listener would perceive symbols which are transpersonal, meaning that the symbols have been passed on from one generation to the next and are the same for all people.

Rationale

Rationale for the current study was twofold. First, there had been no further research to support the original study by Walker and Lunz on which this research was based. Second, since the authors of the original study used two administrators, the current research attempted to control for possible changes in tonality, affect, personality and direction by using only one story teller who attempted to exact as much sameness in presentation as possible. To do so, this storyteller rehearsed on multiple occasions with tape recording and video graphic equipment.

Three hypotheses originally developed by Walker and Lunz (1976) remained intact for this study:

1. A fairy tale will stimulate similar archetypal images in diverse groups of children, as expressed in their drawings, after the telling of the fairy tale.
2. The archetypal images will be similar across ages, cultures, and races.
3. The archetypal images will represent the symbology of the fairy tale: the drawings will not be illustrations of particular scenes in the story.

Method

Subjects

A total of 65 children participated in this study. These participants were elementary students in a school district located within a 25-mile radius of a large metropolitan area. Three groups were selected which represented different ages, cultural backgrounds, races and genders. One kindergarten class totaled 21 and was composed of 15 males and 6 females; one third grade class totaled 21 and was composed of 14 males and 7 females; one fifth grade class totaled 23 and was composed of 13 males and 10 females.

Materials

The fairy tale "Snow White and Rose Red" collected by Jacob and Wilhelm Grimm (1988) was used as the instrument to test the ability of fairy tales to stimulate significant images in the unconscious. Walker and Lunz (1976) chose this story because it holds appeal for listeners of a wide age range and because it contains several outstanding archetypes in a complex symbology. After the telling of the story, the children were given a sheet of paper and crayons or colored markers.

Procedure

One storyteller told the stimulus story, "Snow White and Rose Red," to three groups of children (see Appendix). The same procedure was followed in all three groups. The storyteller told the fairy tale with very little introduction. After the fairy tale, the children were given the following directions: "Sometimes fairy tales bring pictures to our minds. Before you is a piece of paper and some crayons. Draw the picture which came to your mind as you listened to the story." Drawings were utilized because they offer an open instrumentality of expression for the listener to show the images he or she had experienced. The artistic quality of the drawings was not important; therefore, differences in age were not a factor in this task except as it related to developmental levels. The important element to be considered was the image(s) represented.

After the children finished their drawings, each child was asked to tell about his or her picture. The verbal responses were audio tape-recorded and transcribed later in order to note all the labels each child designated for a given picture. There was absolutely no prompting by the adult.

The total time involved for the procedure was 45 minutes. The actual telling of the fairy tale was approximately 15 minutes. A range of 20 to 30 minutes was used for student drawings and responses.

Interpretation

Understanding the tale from a psychological perspective is important in being able to identify and understand the symbols contained within the work. The fairy tale "Snow White and Rose Red" begins with the introduction of the poor widow and her two young daughters. This is a triad of three females representing the feminine psyche. The basic conflict in the story is the lack of a masculine element which is needed for psychic balance. The masculine psyche is represented positively as the bear and the prince and negatively as the dwarf, a triad of the masculine psyche. At the end of the tale the psychic balance is gained by the union of the two triads which represents the most important psychic process, the establishment or restoration of unity and wholeness of the Self. A symbol of unity is the rose which represents wholeness through its spherical dimensions. Roundness (whether in a sphere, globe or circle) represents wholeness. The feminine is also represented as a vessel-like flower, a receptacle to take in or hold like the female reproductive anatomy.

The archetypes present in the fairy tale include: the house, a feminine symbol of the Self represented by the cottage or the palace; the anima or feminine, symbolized by Snow White and Rose Red and the two rose bushes; the animus or masculine, symbolized by the bear or prince in the positive form and by the evil dwarf in a negative form; and unity, created by the combination of the masculine and feminine in the marriage and symbolized by a rose.

Results

General

Table 1 reports the number and percentage of subjects who drew each image. The picture which was drawn by each of the children contains at least one of the four archetypes identified in the original study.

SNOW WHITE AND ROSE RED
TABLE 1: Number and percent of children whose drawings reflected the symbols of the fairy tale

Images	1976 Number of Subjects	1976 Percent of Subjects	1994 Number of Subjects	1994 Percent of Subjects	1994 Percent of Images
House Cottage Palace	14	32	18	28	18
Anima Rose Bushes Two Sisters	8	18	28	43	29
Animus Bear-Prince Dwarf	14	32	32	49	32
Unity Marriage Rose	5	11	11	17	11
Illustration	3	7	12	18	12
Total	44	100	101	—	—

Note. The data pertaining to 1976 is from "Symbols, Fairy Tales, and School-Age Children" by Virginia Walker and Mary E. Lunz, 1976, *Elementary School Journal, 98.*

— Skewed score created by multiplicity of drawings.

The multiplicity of images that appeared in 66% of the drawings caused the researchers to wrestle with how they were to discriminate between illustrations and symbols. The final criteria was a combination of looking at the picture and of paying attention to the explanation given by the child. In order for the drawing to fall into the illustration category, it had to reflect current action in both the explanation and the drawing. It should be noted that 23% of the drawings contained unknown symbols and 26% included images on the backs of the drawings.

Kindergarten

The rainbow, a feminine symbol of hope, did not actually appear in the tale, yet appeared alone in one drawing and with other symbols in four other drawings. The moon (representing the feminine, the maternal, and the unconscious) in connection with trees carries a bisexual meaning, related to lunar and mother symbolism in their feminine aspect. The bear or prince, a positive male image of the animus, appears nine times. This is opposed to the dwarf who appears twice. Pictures on the backs of the paper strongly suggest the presence of the unconscious which, according to Jung, is always at the back of things, metaphorically speaking. All new symbols are feminine with the exception of the tree which is both masculine and feminine.

Third Grade

In third grade the dwarf or negative male image appears twice as frequently as the positive bear or prince. No rainbows are represented in third grade. The onset of sexuality is indicated with the emergence of the cave, representing the womb or vagina, and the presence of the tower, a phallic symbol. The sun is a masculine symbol for the mind, for healing, for heat, for discrimination and for knowledge; jewels symbolize fertility and treasure; birds symbolize spirits or aid from supernatural sources; and clouds represent a feminine manifestation of God, truth or knowledge. The door denotes a passageway from one place to another.

Fifth Grade

An increase in multiple symbols occurs in fifth grade drawings. The positive and negative view of the animus is balanced. Increased emphasis on sexuality is indicated by the number of hidden hands (a symbol of masturbatory guilt, low self-esteem and introversion). Other symbols of sexuality which are represented include: fire (symbolizing erotic life and fertility); chimneys, smoke, and towers (phallic symbols); and aprons (symbolizing covers for sexual anatomy). Also noted is an increase in the number of door symbols which represents the vagina and a passage from one state of being to the next.

Table 2 presents frequencies by grade level for the four archetypal images identified in the fairy tale. A chi square test of independence indicates that the distribution of images in the drawings among the grades is significantly different. This makes a case for the idea that each listener of a fairy tale does attune himself or herself to the unconscious developmental task in which he or she is currently engaged through the selection of appropriate symbols.

TABLE 2: Frequency of images at three grade levels

Image	Kindergarten	3rd Grade	5th Grade	Total
House				
Cottage	1	4	11	16
Palace	0	0	2	2
Anima				
Rose Bushes	1	2	11	14
Two Sisters	4	6	4	14
Animus				
Bear-Prince	9	3	6	18
Dwarf	2	6	6	14
Unity				
Marriage	0	2	0	2
Rose	3	5	1	9
Total	20	28	41	89

$\chi^2 = 15.77$, df = 6, $p < .05$

Discussion

The present data supports the original study conducted by Walker and Lunz in 1976. The number of archetypes that appears in the children's drawings supports Hypothesis 1, 2 and 3 that fairy tales stimulate archetypal images in diverse groups, that the images will be similar across age, culture and sex and, that the archetypal images will represent the symbology of the fairy tale rather than being illustrations of particular scenes in the story.

In the original study, the researchers note that each picture "usually" contains only one of the four original archetypes; however, in the current study multiple images appear and seventeen new archetypes repeatedly used are identified. Current researchers believe that the increased number of archetypes may reflect the increased complexity of our society in the last twenty years since the original study was done. Technology, communications, mixed ethnic and racial marriages, and diverse family systems with multiple mother and father figures all contribute to the intricacies of modern life. The multiple images which appear in the 1994 study are noted to increase in frequency as the grade level increases. This evidence suggests the significance of developmental age in children's increasing ability to grasp complex ideas and concepts. For example, all new symbols at the kindergarten level are feminine. The emphasis on the feminine seems naturally related to the developmental age of the child where the mother is still of primary importance.

Both the frequency of new symbols and the frequency of drawings and symbols on the back of the paper indicate the presence of the unconscious. The abundance of kindergarten drawings with unknown symbols and pictures on the back suggests that the unconscious is less well defended and is more obvious in younger children. These results may also be interpreted as active imagination and fantasy in the unconscious. The five pictures on the back of third grade drawings opposed to only three on the back of fifth grade drawings suggest that as children get older, more is hidden and repressed.

The frequent appearance of the bear or prince, a positive male image, as opposed to the dwarf implies that kindergarten age children have a more positive rather than negative image of the masculine. In third grade, the frequent appearance of the dwarf, or negative masculine figure, suggests that the masculine role models, while more powerful, appear more harsh and more violent. The new symbol of the rainbow that appears in kindergarten drawings is striking because it suggests that the story evokes hope in the children. The absence of rainbows in either third or fifth grade drawings raises the question of whether hope is reduced in these age groups.

Illustrations appear more frequently as grade levels increase. Since the criteria for illustrations was action in both the drawing and in the child's explanation, it might be concluded that there is an increased emphasis or pressure on the child to measure up by doing rather than being. This might signify that the child has been taught to place more value upon external behavior and appearance rather than upon internal feelings and values. It is interesting to speculate what this might mean to society in terms of the development of moral fabric and to the individual in terms of self-esteem. The increase in sexuality in fifth grade seems, again, to underscore a case for developmental age. The door symbol, which stands for passage from one state of being to the next, is particularly significant in this age group since these students will soon be making the transition from elementary to middle school.

Implications for Further Research

This study has important implications for the training of teachers, counselors and day care personnel. There is an identifiable need for trainees to be provided various communication skills, including story telling, in order to understand the emotional and symbolic expressions of children and adults.

Since gaining access to the unconscious through the use of fairy tales is a valid construct, implications for further research are indicated. Additional research on aural versus literary experience would be valuable. It would be useful to expand the number of subjects and grade levels. Video taping of the entire experience would provide a tool to obtain additional information regarding the emotional and nonverbal behavior of the participants. Studies using a variety of populations such as emotionally disturbed children or alcoholics could determine if significant differences in response exist. The storyteller may be able to connect with the disturbed individual in a way which would open a channel of communication, possibly leading to a free expression of feelings.

Jung's hypothesis of archetypes and collective memory has been difficult to investigate experimentally. More attempts to uncover the translation of symbols and archetypes may occur within the next decade (Rosen, Smith, Huston, Gonzalez, 1991). This study is a further attempt to collect empirical data.

In conclusion, this study supports the ideas suggested by Jung. Utilizing fairy tales to stimulate images in the unconscious teaches the child at an early age to pay attention to inner processes. It is here within the Self that values and morals are born and where the spirituality of the individual is nurtured. The future of Western society lies in its ability to bring these qualities back into balance with the current outer focus upon material possessions and physical appearance. In so doing, Jung's emphasis on the balance between the inner and outer aspects of one's being would be reflected in American society.

Appendix

Fairy Tale

Watts (1988) begins the retelling of the fairy tale by the Brothers Grimm as follows: "Once upon a time there was a poor widow who lived in a lonely cottage. In the garden surrounding the cottage stood two little rose trees; one had white roses, the other red" (p. 1).

The tale continues: The widow had two daughters named Snow White and Rose Red because they were like the flowers which bloomed on the rose trees. One was fair and pale like the white roses; the other was rosy cheeked like the red roses. The two children often went into the forest to gather berries and flowers, and no animals ever harmed them. One winter evening when the girls and their mother were sitting by the fireplace, a bear knocked on the door and asked to come in and warm himself. The mother invited the bear in, and soon the bear and the girls were friends. The bear spent every winter evening

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curled by the cottage fire. When spring came, the bear told Snow White that he must go away and could not return until the end of summer. He told the girls that he must go into the forest and guard his treasure from the evil dwarfs, because they steal all they can find and hide it deep in their caves. As the bear left, he tore a piece of his fur on the bolt of the door, and it seemed to Snow White that she saw the glitter of gold through the hole it made.

In the days that followed, the girls met a dwarf in the woods three times. Each time, the dwarf was caught in a different predicament. The first time, the dwarf's beard was caught in a fallen tree; the second time, his beard was entwined in the line of his fishing rod hooked to a fish in a stream. The girls freed the dwarf these two times by cutting off part of his beard. The third time the girls met the dwarf, he was caught in the claws of a huge bird. The girls held onto the dwarf until the bird gave up and flew off. Each time the girls rescued the dwarf, the dwarf screamed and cursed the girls before stomping off.

The last time the girls met the dwarf he had emptied out his precious stones in a secret spot near his cave. When the dwarf was surprised by the girls, he cursed at them. Suddenly, the three heard a loud growling noise, and a large black bear came out of the forest. The dwarf did not have time to escape into his cave, so he tried to convince the bear to eat the girls instead of him. The bear said nothing and with a single blow of his paw killed the dwarf. The girls began to run away, but the bear called them and told them not to be afraid. They recognized his voice and stopped. When he approached them his bearskin fell away and a handsome young man appeared dressed in gold. He said he was a king's son under a spell cast by the evil dwarf. He had been imprisoned and forced to roam the forest as a bear until the dwarf's death. When the girls grew up, the prince married Snow White and the prince's brother married Rose Red. Finally, the old mother went to live with them in the palace where they lived in peace and happiness until the end of their days. The rose bushes in front the cottage were transplanted in front of the palace and bloomed each year with white and red roses.

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> “*Fortunately analysis is not the only way to resolve inner conflicts. Life itself still remains a very effective therapist.*”
>
> –Karen Horney, Our Inner Conflicts

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New Approach to Counseling

Phyllis Rubenfeld

Intrusive counseling, a proactive approach in which counselors establish contact with students and address their needs before they become entrenched problems, shows significant promise as a method of lowering the dropout rate among non-traditional college students. Programs at three diverse universities are described and their results reviewed, and implications for practice are outlined.

Student populations in higher education continue to become more diverse, particularly in large public universities in inner cities. This diversity continues to make counseling an exciting and challenging field. As more and more African-Americans, Latinos, Asians and students with disabilities enter college, along with non-traditional students who need remediation in basic skills such as arithmetic, reading and writing, in developing appropriate study habits, note-taking techniques and classroom behavior, professional counselors must reassess traditional theories and practices, re-tooling many of them to meet the needs of non-traditional students.

Academic remediation programs and counseling services have become fixtures in public institutions of higher learning. Many college administrators and faculty have mixed feelings about this. They believe that remediation should take place entirely at the secondary level, and that counseling should be provided for psychological emergencies but not for the far more numerous, less dramatic failures to understand or to adjust to the college culture and its behavioral norms. My twenty years as a counselor of non-traditional students, however, has persuaded me that many of these students are highly motivated, if confused and disorganized, and that they will often benefit from counseling in dramatic ways. This article focuses on so-called intrusive counseling and the role it can play in the non-traditional student's college experience.

Non-traditional students, as a group, come to college with unusual deficits. They generally bear unusual burdens in their personal lives. Therefore, early identification of problem areas is more vital in regard to this population than it is for others. Many of these students have heavy work schedules outside of college, and some have household responsibilities such as cleaning, shopping, cooking and caring for younger siblings. No matter how necessary these activities are, they take time and energy away from study, sometimes affecting attendance as well. Some students realize that just attending class, as many of them did in high school, is insufficient for college success, and for most the sheer amount of time required to complete assignments comes as a shock. Added to the academic strain, this kind of culture shock does much to explain the rate of attrition among non-traditional students and the fact that most withdrawals among this population occur during the first year (Commission on the higher education of minorities, 1985; Szutz, 1989).

By addressing these initial problems as they occur, block programming and freshman seminars can have an impressive impact on the non-traditional students success rate. In block programming, students are registered for the same courses during the critical first semester and travel together as a cohort, receiving the same remedial placements, sharing instructors and counselors. Counselors are responsible for coordinating the needs of students, instructors, and tutors and for identifying sequences of courses for each block. Block programming has been shown to be extremely effective in ameliorating feelings of loneliness and alienation, as well as aiding retention. One study found that "after one semester the course passing rates of the block group were significantly higher in math ($p < .001$) and reading ($p < .05$), and their unofficial withdrawal rate was significantly lower ($p < .01$) than a control group of students and that after seven years, the block programming group had significantly higher graduation rate" (Fuentas, 1994a, p.87). The intrusive counseling approach begins when the instructors voice their concerns to a student's counselor. The counselor contacts the student by phone and/or in writing to encourage him/her to visit the counselor. During this visit the counselor will identify areas of greatest need and/or anxiety:

- lack of financial resources to meet college expenses
- academic skills deficiencies
- vague education and career plans
- difficulty in adjusting to campus life
- difficulty in adjusting to the role of student
- family and domestic issues
- time management issues
- job conflict (Martinez, 1985)

It is important for counselors to remember that many non-traditional students' initial attitudes towards college are determined by their experiences in high school, where counseling usually occurred when the student was placed on detention, or was in trouble, or was a referral, which traditionally resulted in a transfer to another school or in being placed in a more restrictive setting, such as special education.

Non-traditional students who have difficulty in college usually have familial and financial problems (Wimberly, 1992; Baxter & Stanley, 1992). Frequently these college students think that their financial aid should be shared with their parent(s) even if this means not having carfare or money to buy textbooks. Even so, parent(s) may resent seeing their children having fun and hanging out in college, and they may increase their household responsibilities. This often engenders resentment on the part of the students and reduces time available for schoolwork. At the other extreme, students who have been on their own for many years may avoid seeking counseling voluntarily and may be reluctant to engage in the counseling when it is urged upon them.

Early intervention through intrusive counseling places students in a position where they must decide whether or not they want to take responsibility for their school behavior. Intrusive counseling is the alternative to traditional counseling. Intrusive counseling is aggressive; the counselor assesses the student's needs and actively seeks the student out, rather than waiting for the student to seek counseling after recognizing whether or not a problem exists.

Martinez's (1985) approach to intrusive counseling focuses on contacting the student in writing and by phone in order to inform the student about the instructor's concern. In addition, the student is informed of the support services available for addressing his/her problems. Martinez also found that students who need services the most tend to request them the least. Therefore, the need for intrusive counseling is critical if these students are to be helped to graduate. Many of the neediest students show little awareness of their deficits and their need for remediation. Some students believe that having taken courses such as math, writing, reading, and science in high school, excuses them from reviewing these materials daily. The underlying reason for these actions is the need to believe that one is as good as the majority group at one's college. It is difficult for students who need remediation to avoid being stigmatized as "unintelligent, out of place, and a drain on the taxpayers" (Fuentas, 1994b). In order to commit the amount of study time required to achieve college-level proficiency, the student has to admit that he/she is not like the majority group academically. This is an area where the counselor is of critical importance. The counselor may assist the student by explaining that the different academic experience(s) of various students in high school resulted in the need for remediation among some of the students. It is imperative to show that high schools in depressed socio-economic neighborhoods usually have depressed school curricula (Wimberly, 1994). This continues the cycle of shortcoming and failure. The characteristic of intrusive counseling is based on the assumption that a college cannot be passive and wait for students to seek advisement and counseling.

Intrusive counseling is a proactive approach in which the counselor takes responsibility for establishing contact with students, addressing the students' needs before obstacles become entrenched problems and/or barriers to success. Although intrusive counseling is a non-traditional approach to helping students, it may be necessary in order to improve the students' chances for graduation. For intrusive counseling to be effective, it is critical that the classroom faculty member receive training in order to understand and to recognize signs of anxiety, depression, inappropriateness. This is to insure appropriate, early referrals to intrusive counseling.

If universities are committed to educating and graduating non-traditional students they should provide support services for them in the following areas: 1. diagnostic testing to pinpoint weaknesses and strengths; 2. individual intrusive advisement and counseling to facilitate opportunities to learn and maximize adjustment; 3. learning centers and other support services to help non-traditional students reach standard levels of performance and; 4. relevant cultural activities. Glennen, Baxley, & Farren, (1985) found that psychological and personal issues faced by non-traditional college students are extensive. When they are coupled with the normal pressures of college life they often result in the urge to drop out of college. Universities have an obligation to enhance students' chances for success since they admit non-traditional student. At Western New Mexico University, Portales, the intrusive advisement method resulted in the following over a period of three years:

25% reduction in minority attrition

6% increase in the number of minority graduates

8% increase in the number of minorities achieving Dean's List

5% increase in minority employment after graduation (Astin, 1993)

Although intrusive counseling at the University of Maryland in Baltimore meant calling students, meeting on a weekly basis, teaching study skills, and tutoring, their results, although not statistically significant, confirmed the feasibility of establishing a supportive mentoring relationship by phone (Astin, 1993).

Lopez (1988) states that when recruiting students from special populations, it is especially important that services designed to enhance the students' performance and retention be made available. If this is not the case, the open door very rapidly becomes a revolving door. This is because the high rate of recruitment of these students is matched by a high rate of attrition. Intrusive advising requires that the adviser take an active role and seek contact with students rather than waiting for students, once in academic difficulty, to come to the adviser.

At Central Washington University in Ellensburg, Washington, faculty practicing the intrusive counseling approach must meet with students twice a week (Astin, 1993). The counselor and the student review class assignments, study schedules and any graded work. This approach of intrusive counseling lasts for one year. The program's expectations, following the initial year, is that students will have established positive study habits, enabling them to be successful on their own. Intrusive counseling has been effective in increasing retention (Astin, 1993). Although intrusive counseling is not totally responsible for the enhanced academic performance of these students, tutoring, financial aid, basic skills, career planning and ongoing intrusive advising provide the necessary nexus to make connections for these retention services (Astin, 1993).

Although intrusive counseling challenges the traditional counseling philosophy of starting where the client is at and waiting for the student to come to the counselors seeking help, intrusive counseling is often the only way to break into a cycle of failure that other methods cannot change. Furthermore, intrusive counseling has the ability to empower the student. It is an active process in which the student must participate by either accepting or rejecting his/ her counselor's overt approach to engage him/her. The traditional counseling approach allows the student to determine whether or not he/she needs counseling intervention which, as a freshman, usually is based either on negative high school experiences or on an inability to assess his/ her possible level of need. Expecting an 18 year old to have this level of insight may be unrealistic. As a result, those of us who are college counselors may be placing these students at a decided disadvantage. As with most things in life, when we try a specific approach and it results in little success, it is time to assess alternate methods. It is incumbent upon counseling services at universities to consider intrusive counseling as a promising way of lowering the dropout rate of non-traditional students.

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> “*Neurosis is the way of avoiding non-being by avoiding being.*”
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> –PAUL TILLICH, *THE COURAGE TO BE*

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> *There are more things, Lucilius, that frighten us than injure us, and we suffer more in imagination than in reality.*
>
> –Seneca, Epistulae ad Lucilium

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Managed Care and Health Care Reform: Implications for Professional Training and Practice

Tony D. Crespi

Mary E. Steir

The mental health care delivery system has been undergoing massive changes in the United States. Reductions in health care benefits, increased focus on provider credentials, aggressive competition among health care providers, and enhanced attention to master's level practice are areas increasingly changing the complexion of mental health practice. The current status of health care reform and mental health services are discussed along with critical issues impacting professional training and practice for mental health counseling. Based upon current knowledge, specific implications and recommendations are considered.

Managed care and health care reform have dramatically altered the delivery of mental health services in the United States. Already, in San Diego, three major health maintenance organizations (HMOs) care for over 90% of the population who have health insurance (Patterson & Scherger, 1995). Elsewhere, on Capitol Hill, the major health care reform bills have suggested moving medicaid into the same insurance pools as those with private insurance (Sullivan, 1995). Also, managed care companies in some states have won contracts to manage medicaid funds. Given that 32 million children and adults receive services through medicaid, changes in the management of Medicaid funds alone will dramatically impact health care professionals.

Across the United States, managed care has increasingly changed the contours of practice for those providing mental health counseling. Pike and Piercy (1990), for example, note that cost-effectiveness is going to become increasingly important in therapy. Given that certain patients do not demonstrate significant improvement even with unlimited mental health services

(Wallerstein, 1986), the press to curtail excessive treatment may seem somewhat understandable. At the same time, mental health practitioners recognize that the dimensions of providing treatment within the context of a managed care environment are extraordinarily complex and require the ability to operate in a system which has not historically supported mental health (DeLeon, 1995).

Within this volatile environment, many counselors have been concerned about reduced access to mental health services by clients. Fox and Leichter (1991) suggest that health care rationing may even become necessary. Yet, unknown to many providers, it has also been suggested that managed health care could actually lead to an increased demand for mental health services. Crane (1995) has suggested that the demand will increase as such problems as divorce, addictions, violence, depression, and abuse increase.

Within this changing environment, it is not surprising that mental health clinicians feel unprepared and uncertain about their future (Austad, Sherman, & Holstein, 1993). Donovan, Steinberg, and Sabin (1994) suggest that without an introduction to the issues surrounding managed care impacting health care providers, the thousands of clinicians entering managed care networks over the next decade will experience difficulty.

Fundamentally, it is crucial for counselors to become aware of the changing contours of health care practice. The present article is intended to stimulate discussion, while providing an overview of key issues involving managed care. Without qualification, the health care system is undergoing a dramatic transformation. Will consumers in need of mental health services receive critical care? Will the demand for mental health services increase or decrease? What are the opportunities for mental health counselors? What are the prospects for M.A./M.S. clinicians?

Cost Control Versus Social Ills

Health care costs are escalating at a startling rate. Within this arena, managed care is seen as a vehicle for cost control (Patterson & Scherger, 1995), which is increasingly impacting mental health providers. More importantly, despite the movement toward managed care, the majority of mental health counselors have not appeared to fully appreciate the impact of managed care on the shape of professional practice. In a discussion targeted at psychologists, VandenBos (1993) suggests that providers must adapt to survive. Certainly the same can be said for counselors.

At least intuitively, mental health counselors seem worried, particularly about the possibility of increasingly limited services. Unfortunately, the idea of limited mental health services is a real possibility. Many managed care companies limit provider panels and require providers to request authorization for treatment at periodic intervals. From questions about potential breaks in confidentiality to concerns regarding the managed care networks emphasis on cost effectiveness rather than client needs, counselors must be prepared to increasingly understand and function within a rapidly changing health care system. At the same time, counselors recognize an increasing population of people in need of services.

Citing areas of crisis where mental health treatment seems necessary is not difficult. Looking just at women, it has been noted that approximately one in three women experience sexual abuse (Russell, 1986). In addition, severe, repeated violence has been reported in approximately 1 in 14 marriages (Dutton, 1988). Clearly, the mental health needs for victims of physical, sexual, and emotional abuse are large.

Relative to children and adolescents, Jones (1995) suggests that well-adjusted youth are quickly becoming a minority. In fact, according to the Federal Bureau of Investigation (1994), 3.49 million young people under age 21 were arrested in 1993. However, juvenile crime, delinquency, and violence are only part of the range of problems facing youth. Globally it appears as if children face an epidemic of psychological traumas. For instance, recent research has addressed issues ranging from child maltreatment (Thompson & Wilcox, 1995) to increasing exposure to violence (Osofsky, 1995).

In terms of long-term mental illness, it has been reported that approximately two to three percent of the population is impacted. In fact, Carling (1995) states that it was found a dozen years ago that the majority of the 1.7 to 2.4 million Americans with long-term mental illness are also struggling with poor housing and inadequate support services. How will these individuals be impacted by managed care?

Clearly, the breadth and depth of issues facing children and families is frightening. Quite simply, as long as such issues as family violence, rape, substance abuse difficulties, and emotional abuse continue unabated, there will remain a strong need for mental health treatment.

Critically, given the changing climate of health reform, if mental health practitioners are to function effectively and provide much needed services, counselors need to be knowledgeable about managed care. This is particularly true since it appears that participation in managed care for most citizens will become a reality (Crane, 1995).

One option, according to Donovan et al. (1994) involves the establishment of a network between training programs and managed care facilities—in fact, there is already some precedent for this. In psychiatry, for instance, residents from the University of Washington Medical School are involved in cooperative managed care programs. In psychology, interns from the California School of Professional Psychology at San Diego have been receiving training involving a managed care facility. Unfortunately, cooperative arrangements between counseling programs and managed care facilities are either not widely documented in the professional literature or simply still lagging in development.

Students from M.A./M.S. programs, however, could be very appealing to managed care organizations. Neilsen (1995) notes in a discussion on graduates of M.A./M.S. programs in psychology that master's level providers can help contain psychological service delivery costs. In a discussion involving M.A./M.S. clinicians trained in marriage and family therapy, Crane (1995) notes that, "Practitioners with master's degrees may compete well against those with doctoral degrees for positions in managed care organizations because their salaries can be lower than those of doctoral degree holders." (p. 121)

Consistent with these examples, it would be myopic for counseling programs not to consider forging training alliances with managed care facilities. In fact, not only could such alliances be helpful to counselors, providing much-needed knowledge on funding problems and barriers, but potentially such alliances could be extremely useful to children and families. Myers (1994) notes that with training, redeployment of funds could support innovations in service delivery to children and families, resulting in treatment innovations. Without learning the intracacies of managed care, however, such possibilities will be extremely limited.

Managed Care: Implications For Practice

In a fundamental way, professional counselors need to become knowledgeable about the implications of managed care. Still, faced with a dramatically changing health care arena, what specifically should counselors consider relative to managed care?

1. The practice of mental health counseling must be focused and responsive to both managed care reviewers and to client expectations. Treatment outcome must be measurable and clear documentation of treatment progress and outcomes must become part of training and practice. In a specific way, focused treatment plans, time-limited treatment, along with effective case management and outcome must be emphasized.

2. Just as hospitals are reducing costs by utilizing physician's assistants, so master's degree professionals may become more attractive as managed care and mental health agencies seek to reduce and contain costs. What this means is that master's degree professionals will be seen as more cost effective and

practical. Counselors need to educate managed care groups about professional skills and the benefits of employing M.A./M.S. clinicians.

3. Overall, service delivery will move toward a model utilizing a primary physician as case manager, with mental health specialists working in interdisciplinary teams. Professional counselors need to become comfortable working in interdisciplinary models and learn more about current systems operating in the managed care environment.

4. Assessment data will increase in importance. Both process and outcome assessment, as well as assessment methodology will become increasingly important for mental health providers. Counselors need to appreciate the tradition of assessment methodology within the profession and educate managed care administrators about assessment training and competencies inherent to counselors.

5. The importance of state licensing, national certification, and specialty credentialing will become increasingly important in order to gain access to provider panels. Just as psychiatrists typically acquire state licenses and national board certification, so virtually every mental health provider will need to acquire appropriate regulatory credentials in order to function as an approved provider of mental health services. Counselors must understand the importance of regulatory credentials in the landscape of current mental health practice.

6. Related to the issue of state licensing and national certification, continuing education requirements can be expected to increase as provider panels seek documentation regarding on-going education and training in contemporary treatment methodology. Increasingly, managed care companies want documentation of training that supports stated competency areas. Continuing education must receive increased attention from both training programs and practitioner groups.

7. While master's degree professionals will become more attractive in the managed care environment, the overall competition to provide mental health services will increase. The increasing numbers of Psy.D. practitioners from professional schools of psychology alone will substantially increase the number of competing providers. To compete effectively, M.A./M.S. practitioners need to work to raise the stature of master's prepared clinicians as viable and attractive providers.

8. While public schools special services units have generally remained outside the health care debate, special services staff within the schools will increasingly find linkages to managed care. Both insurance companies, as well as state boards, will expect similar standards of care and training for clients regardless of practice setting. All counselors, in all settings, need to understand the implications of managed care.

9. New opportunities will arise for health care professionals with interests in such areas as health care administration, quality assurance, and peer review. Partly because of this, graduate training programs may need to develop innovative training options. Dual degree options linking graduate training with degrees in such areas as business and public health (e.g., M.B.A., M.P.H.) could increase employability.

10. Increased emphasis and interest in clinical research can be expected to increase. While today quantitative research methodology dominates clinical research journals, qualitative research methodologies will increasingly become evident. Students and practitioners need to appreciate the place of clinical research and research methodology. They must also understand the role research can play in substantiating the cost effectiveness of mental health interventions with clients.

Implications For Training

If counselors are to survive and flourish in a managed care environment, it is important to begin to understand the managed care system and to explore new and innovative training opportunities. Berkman, Bassos, & Post (1988) note that managed care organizations will soon become the primary gatekeeper for mental health services.

Given this changing landscape, training programs need to responsively address the new contours of practice. Already several parallels have been drawn between new training options in psychiatry and psychology which are applicable to counseling.

Unfortunately, there is a paucity of literature specifically addressing innovative training options for M.A./M.S. practitioners. Innovative training programs linking university training with managed care organizations would be one viable option. Such programs providing options for multiple credentialing as a professional counselor, school psychologist, or marriage and family therapist could enhance employability. Along with multiple credentialling, supplemental degree training in business or health care administration would also increase its attractibility. Clearly, innovative training options need to be showcased in order to educate students and practitioners about new professional opportunities.

While in decades past, a graduate degree was often sufficient to introduce students to careers in mental health, the reality of current fiscal forces suggest a dramatically changed picture for the future. Almost certainly, only clinicians with specific documented skills, state licenses, and the ability to produce measurable results will be able to work in the mental health care arena of the 21st century. Moreover, in the current climate of limited resources and increasing competition among mental health provider groups, it is clear that master's degree practitioners need to continue lobbying efforts to obtain and up-grade state licensure. Given research that indicates few differences between counseling psychology and clinical psychology (e.g., Johnson & Brems, 1991; Watkins, Schneider, Cox, & Reinberg, 1987) and the sense that master's degree professionals are likely to be perceived by managed care groups in a very positive light (Crane, 1995), there is every reason to believe that counselors can be effective in the managed care system. Effectiveness will occur if the following are employed: managed care groups are properly educated; providers are properly trained to understand managed care; and licensing and credentialing efforts continue forward. If this happens, there will be cause for optimism for an expanding role for master's clinicians in the managed care marketplace.

Conclusions

Counselors face a dramatically different health care system today than existed previously. Most notably, the increasing role of managed care is transforming the contours of mental health services. There has been a shift from the traditional third-party reimbursement plans (i.e., indemnity plans) to the newer managed care models. Furthermore, counselors must incorporate new information and skills into their repertoire to work effectively in the managed care environment.

On a discipline-wide spectrum, the implications of managed care on the practice of mental health counseling are noteworthy:

* Emphasis on cost-containment,
* Assessment and documentation of measurable outcomes,
* Increased interdisciplinary cooperation,
* Increased provider competition,
* Increased emphasis on licensing and specialty certifications,
* Continuing education initiatives, and
* New opportunities within health care administration.

Fortunately, there is reason for optimism. Indications exist, for instance, that because cost containment is so important, master's degreed professionals should be able to compete very effectively against doctoral professionals. In order to compete effectively, we need to become more knowledgeable about managed care, pursue licensing efforts, and educate both the public and managed care companies about the profession.

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> “*Convictions are more dangerous enemies of truth than lies.*”
>
> –FRIEDRICH NIETZSCHE,
> *HUMAN, ALL-TOO-HUMAN*

> “*Education is what survives when what has been learned has been forgotten.*”
>
> –B.F. SKINNER, IN *NEW SCIENTIST*

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Counseling Clients with HIV and AIDS: A Review of Ethical and Legal Issues

Burnice L. Hayes

The Acquired Immune Deficiency Syndrome (AIDS) epidemic is affecting increasing numbers of the population daily. Counselors are working with HIV (Human Immunodeficiency Virus) infected clients and the special needs they bring into the therapeutic relationship. Legally and ethically, the professional guidelines pertaining to HIV and AIDS leave the majority of counselors uncertain regarding policies governing their conduct. These ethical and legal issues warrant clarifying and updating since many counselors are unable to assess their relationships with this growing population.

Due to the overwhelming psychological and social effects of AIDS and HIV infection, counselors are being called upon to work with this population (e.g., persons with AIDS, family members, lovers, friends, colleagues). Mental health professionals are finding themselves confronted with ethical issues involving clients who have AIDS or are infected with HIV. Ethical and legal guidelines pertaining to AIDS are in desperate need of clarification and updating. Harding, Gray, and Neal (1993) state that "the literature is clear, however, that most perplexing ethical and legal issue for helping professionals working with AIDS is the legal and ethical extent of the 'duty to protect' third parties" (p. 297). Stanard and Hazler (1995) state "the ethical codes and professional literature offer professional guidance but clearly have inherent contradictions and gaps" (p. 399).

According to Corey (1991), ethical codes of various professional organizations have not defined the limits of confidentiality with regard to clients with AIDS who continue to be sexually active without informing their partners. Melton (1988) states that "the difficulty of the ethical and legal problems is exacerbated by both the rapid growth of information about AIDS (and,

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therefore, continual change in the calculation of risks related to possible ethical breaches) and the dearth of case law and definitive philosophical analyses about such matters" (p. 941).

Counselors are faced with critical issues pertaining to ethical and legal dilemmas regarding AIDS. In most cases, these dilemmas are rather complex and warrant examination. In order to understand and assess a counselor 's responsibility to clients and society, an examination of existing procedures and policies addressing HIV and AIDS follows.

Confidentiality

Many professional organizations provide guidelines pertaining to ethical concerns of confidentiality when working with clients with HIV and AIDS. According to Harding et al. (1993), confidentiality regarding this issue raises controversial and complex reactions. Counselors should understand how to compare and contrast policy directives or position statements dealing with HIV and AIDS. "It is also important, however, to recognize that directives change with the release of new medical information, court challenges, and changes in the leadership of each professional organization" (p. 298).

The American Counseling Association (ACA, 1992) provides professionals with ethical standards addressing limits of confidentiality. Members of ACA have the duty to inform appropriate authorities when a client or other person is thought to be in clear and imminent danger. The following position statement was approved by the ACA Governing Council:

> The American Counseling Association (ACA) is committed to the quality of life for people with Acquired immunodeficiency syndrome (AIDS) and their families, friend, and partners, and to preventing the further spread of the disease. To the end, ACA supports (a) protections against discrimination based on human immunideficiency virus (HIV) status or diagnosis of AIDS-related conditions; (b) comprehensive targeted education programs; (c) comprehensive counseling programs to accompany HIV testing; (d) training of counselors and human development professionals; (e) behavioral and psychosocial research on AIDS; (f) and involvement of ACA members in local, state, and federal governmental decision and policy making. (p.1)

Although, ACA recognizes the significant role that counselors play in controlling the spread of AIDS, there are no specific practical guidelines pertaining to confidentiality regarding this issue.

The American Psychological Association (APA, 1991) provides a policy on legislation regarding confidentiality and the prevention of HIV transmission.

However, specific guidelines for providers regarding a duty to warn the third party still does not exist at this time. The APA (1991) states the following:

> 1. A legal duty to protect third parties from HIV infection should not be imposed.
>
> 2. If, however, specific legislation is considered, then it should permit disclosure only when (a) the provider knows of an identifiable third party who the provider has compelling reason to believe is at significant risk for infection; (b) the provider has a reasonable belief that the third party has no reason to suspect that he or she is at risk; and (c) the client/patient has been urged to inform the third party and has either refused or is considered unreliable in his/her willingness to notify the third party.
>
> 3. If such legislation is adopted, it should include immunity from civil and criminal liability for providers who, in good faith, make decisions to disclose or not to disclose information about HIV infection to third parties. (p.1)

The National Association of Social Workers (NASW, 1993) recommends that its members fully inform the client about limits of confidentiality. The NASW provides a policy statement that addresses specifics about duty to warn when working with clients who have AIDS or are infected with its virus. The policy states the following:

> In the absence of standard statutory or regulatory guidelines, practitioners and agencies may perceive a responsibility to warn third parties of their potential for infection if their spouses, other sexual partners, or partners in intravenous drug use are HIV infected and the partners refuse to warn them. Agencies have a responsibility to establish clear guidelines for workers whose clients place others at risk of infection. These guidelines should be based primarily on existing standards of confidentiality as stated in the NASW Code of Ethics (1993), the "duty-to protect" principle established by the Tarasoff (1976) decision, and emerging state laws concerning the notification of partners and the duty to warn them.
>
> Social workers should first use the strength of the client-worker relationship to encourage clients with HIV infection to inform their sexual or needle-sharing partners of their antibody status. Clients should be counseled regarding existing partner-notification programs that can be used. If the clients cannot or will not inform their sexual or needle-sharing partners, the social worker must inform the clients of the avenues, if any, they are mandated to follow. Social workers have a responsibility to consult with other practitioners and to consider legal counsel if they feel they have a duty to warn. (p.5)

Duty to Warn and Protect

The major question regarding AIDS-related ethical and legal issues is the duty to protect third parties from HIV infection. HIV and AIDS clients who are sexually active are placing uninformed sexual partners at risk. Gray and Harding (1988) present a process for counselors that helps the client assume responsibility for informing current sexual partners. This process includes educating, consulting, and supporting clients. For example, "the counselor needs to provide or make available information about the ways the virus is spread, keep abreast of the client's medical condition through consultation, and actively help the client face the difficult situation of informing his or her sexual partner(s)" (p. 221). When this process is not effective with clients, Gray and Harding suggest that counselors (1) first inform the client of their intention to breach confidentiality, (2) inform the identified sexual partner(s) directly, and (3) inform the state public health officer, if the sexual partner(s) is/are anonymous.

Many counselors are applying a ruling of a California case to AIDS-related situations. The case of *Tarasoff v. Regents of University of California* (1976) seems to be impacting the mental health profession more than any other legal case. According to Lamb, Clark, Drumheller, Frizzell, and Surrey (1989), "the appeal court ruled that psychotherapists have a duty to warn the victim or others likely to have contact with the victim when the professional determines, or should determine, with professional skill and knowledge, that such action is necessary to prevent danger" (p. 38). The Supreme Court of California upheld the duty to warn and broadened it to include the duty to protect.

Since the ruling of the Tarasoff case, many mental health professionals see this as a sufficient reason to breach confidentiality with AIDS clients. AIDS is a life-threatening disease. Therefore, some professionals consider AIDS-related situations as a duty to warn uninformed sexual partner(s) and protect society from HIV transmission. Melton (1988) states that "psychologists interested in applying the Tarasoff line of cases to their AIDS-related practice should learn the law prevailing in their states" (p. 941). In other words, counselors must take caution when interpreting and applying the ruling of the Tarasoff case to their situations.

One can see that the role of the counselor is expanding. Not only are counselors responsible for the safety of the client, but they are also responsible for any third persons who could possibly be threatened by the client. Corey (1991) states that counselors are faced with the challenge of protecting others from serious harm with minimal intrusion on the privacy of the client.

Concerns for Groups

When individuals are diagnosed as HIV positive, support groups can help them make the transitions through several developmental stages. According to Posey (1988), " the goal in counseling or support groups is to assist each person in the process of developing a style for dealing responsibly with the AIDS-related condition by caring for oneself and others" (p. 227). The ethical dilemma of confidentiality with AIDS-related support groups is of great concern to counselors and other mental health professionals. Ethical guidelines and standards regarding confidentiality with these support groups are not addressed nor are there definitive legal precedents to guide group leaders (Gazda, 1989). Therefore, group leaders must be aware of certain concerns that may arise and must develop ways for effectively dealing with those critical issues. A major concern to group leaders, as well as members of AIDS-related support groups is confidentiality. Posey (1988) states that "the purpose of confidentiality is not to conceal the condition but to help members handle the information with responsibility to themselves as well as others" (p. 226). The importance of confidentiality must be emphasized frequently within the group. In cases of confidentiality issues resurfacing, the group leader must redefine, discuss, and answer questions regarding this ethical concern. Not only is confidentiality a responsibility of the group leader, but also a responsibility of the group members as well.

CONCLUSION

The controversy around AIDS and confidentiality is affecting counselors as well as other mental health professionals. Counselors who work with AIDS clients are confronted with ethical and legal issues. Some professional organizations provide guidelines and policies for addressing ethical questions, but many of these standards are not specific, leaving counselors uncertain. Therefore, these guidelines and policies warrant clarification and updating.

Since many ethical guidelines pertaining to AIDS and confidentiality are vague and unclear, Harding et al. (1993) suggest that "counselors (1) inform all clients of confidentiality limits, (2) consult with other professionals about ethical dilemmas, (3) document meticulously, (4) educate all clients about AIDS transmission processes, and (5) demonstrate compassion and sensitively to the very real issues of discrimination and stigmatization" (p. 303). Addressing these ethical issues is a complex and difficult task. Being faced with this salient challenge, counselors must interpret the recommended guidelines. They must also adopt a framework for ethical decision making regarding AIDS and confidentiality.

Some counselors consider it a duty to warn uninformed sexual partners, therefore breaching confidentiality. Applying the Tarasoff ruling to AIDS-related situations may be used as justification for many counselors to breach confidentiality, but Melton (1988) strongly recommends that counselors learn the law prevailing in their state.

Counselors must assume the responsibility to keep abreast on ethical and legal issues pertaining to AIDS and inform all clients of confidentiality limits. Most of all, counselors must demonstrate sensitivity and provide active support to their clients who have AIDS or are infected with the virus. Furthermore, mental health professionals must continue to be aware of the need to address the controversial issues surrounding AIDS and confidentiality.

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> “*Opportunities are usually disguised as hard work, so most people don't recognize them.*”
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> –Ann Landers, attributed

> “*Learning teacheth more in one year than experience in twenty.*”
>
> –ROGER ASCHAM, *THE SCHOOLMASTER*

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Collaborative Interventions for Children with Chronic Behavior Problems

Diane Dempsey Marr

When compared to more traditional type services, collaborative mental health services have the potential to better serve children with chronic behavior problems. Focused on molding community services to the needs of children and their families, collaborative interventions support mutual goals as well as shared responsibility and resources. Behavior can be addressed across environments using comprehensive programming designed to acknowledge all aspects of the presenting concerns. In this article, some basic concepts underlying collaboration are outlined. Two case studies are used to demonstrate their application.

Many Americans today are worried about their country's children. Juvenile violence and crime are viewed by most as reflections of diminishing respect for authority and the basic rights of others. Popular opinion lends to the growing alarm over what is perceived to be a national epidemic. Rather than just an overemotional reaction to well publicized isolated incidents, we indeed have legitimate grounds for our concerns. The mental health of the nation's children is being challenged. According to a report published by the Institute of Medicine (1989), the number of children with behavioral and emotional problems has been growing at a breathtaking pace with few children receiving adequate treatment.

Two examples which account for only a portion of children's behavior problems are oppositional defiant disorder (ODD) and conduct disorder (CD). It has been estimated that between 1.3 and 1.8 million children in the United States have the potential to be diagnosed with ODD or CD (Webster-Stratton, 1993). According to the DSM-IV (American Psychiatric Association, 1994), a persistent pattern of negative behavior is typically established early in childhood and can include lying, stealing with or without confrontation of the victim, defiance of authority, physical aggression or cruelty, truancy, and running away from home. Children with these disorders show little initiative in taking responsibility for their negative behavior, often attributing blame to others. The lack of guilt or remorse that often accompanies these disorders assists in the maintenance of psychological comfort levels with regard to the wrong doing. Unlike those who encounter their unpleasant or destructive behavior, the children themselves may see little or no need to learn or engage in more functional behaviors. The absence of psychological discomfort paired with the serious and persistent nature of many of the problem behaviors highlight the need for early intervention across all environments in which the children interact.

In addition to ODD and CD, other sources of childhood behavior difficulties may encompass such mental health problems as chemical dependency or attention deficit disorder. Regardless of the origin, children who display chronic behavior problems represent a formidable challenge to families, schools, and communities alike. The difficulties which arise as a result of interacting with such children are numerous. Pressure placed on primary caregivers is likely to intensify already existing stressors or depression and results in physical exhaustion, low self-esteem, and a sense of isolation. In attempting to ameliorate or control negative behaviors, the majority of family resources (time, attention, and/or finances) may easily be consumed in the struggle, leaving little for siblings and parents. Within the classroom, chronic problem behavior has the capacity to frequently disrupt the learning environment and create unhealthy interactions between students. It is of no surprise that teachers often feel overwhelmed by the competing demands placed upon them when working with students who are behaviorally challenged.

What resources exist to help address the growing challenge created by chronic behavior problems? And what can be done to improve children's mental health services?

Individual systems such as juvenile justice, social agencies, and schools have attempted, with fleeting success, to deal with various aspects of the problem. However, each system has been overwhelmed by the sheer volume of need and the complexity of the task. With regard to counseling, community based mental health services available to children and their families are often limited in scope (Collins & Collins, 1994; Cohen, Singh, Hosick & Tremaine, 1992; Mordock, 1990) and typically provide only fragmented assistance (Cohen et al., 1992; Collins & Collins, 1994; Zahner Pawelkiewicz, DeFrancesco, & Adnopoz, 1992). The lack of intermediate care options has unfortunately resulted in either a high proportion of children failing to reach mental health treatment (Cohen, Kasen, Brook, & Struening, 1991; Zahner et al., 1992) or the overutilization of costly and often times inappropriate placement in residential or inpatient facilities outside of the community (Mordock, 1990).

Given the multifaceted nature of the problem, no one entity in isolation can hope to create positive, long lasting change in the target population's behavior. If we are to realize any substantial degree of success, active involvement must be sought from community support agencies as well as community groups (fraternal organizations, businesses, churches), families, extended families, neighborhoods (Melaville, Blank, & Asayesh, 1993), and the children themselves. Fiscal (Epstein, Cullinan, Quinn, & Cumblad, 1994; Mordock, 1990) as well as human resources (expertise, skills, talents, and time) must be combined to meet the demands of the challenge. Cooperative partnerships will not suffice, as their focus is to meet individually established goals within the confines of already established services and regulations (Melaville et al., 1993). Instead, what is needed is a flexible and creative collaborative community partnership in which mutually defined goals are established to meet the needs of individual children and their families. According to Melaville and his colleagues, this type of partnership, "...offers the possibility of real service integration and the best chance of restructuring the current patchwork of categorical services into a profamily system" (p. 15).

Several communities have formally begun the process of developing and implementing collaborative pro-family services (Behar, 1986; Melaville et al., 1993; Mordock, 1990). On a smaller scale, others have informally experimented with the new approach. This article outlines some basic concepts that are fundamental to collaborative interventions. Through the use of case studies taken from two rural elementary schools, each serving approximately 375 children, application of some of these concepts will be demonstrated.

Collaborative Interventions

Defining the Challenge

Children with chronic behavior problems experience many difficulties as a direct result of their inappropriateness, defiance, and/or aggression. Often they feel isolated (Cohen et al., 1992), have poor academic achievement (Epstein et al., 1994; Short & Shapiro, 1993; Webster-Stratton, 1993), and meet with rejection and disapproval from peers (Short & Stratton, 1993) and adults alike. Even with the display of appropriate behavior, others may remain hypervigilent, judgmental or negative, thus disallowing for the occurrence of positive reinforcement. Low self-esteem and depression are likely to be their constant companions.

Negative environmental responses to chronic acting out are often punitive in nature, relying on corporal punishment, exclusion, or incarceration. Unfortunately, these aversive responses often lead to increased anger and aggres-

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sion and fail to teach the children proactive behaviors necessary for success. At a less intense level of response (nagging, scolding, long speeches, nonsystematic intervention), skilled children are able to determine the degree of discomfort they are willing to experience in exchange for the opportunity to engage in negative behavior. For example, a child may continue to be truant if he or she knows that the consequence of being grounded at home for a day, although negative, is tolerable. The problem behavior provides a higher magnitude of reinforcement than the punishment dispensed provides for a deterrent.

Positive environmental responses such as increasing structure or implementing a single locale behavior modification program may also prove to be inadequate. These approaches often fail for two reasons. First, because they provide little or no skills training and depend solely on external controls, when removed problem behaviors once again emerge. Secondly, many traditional behavior programs are designed to, as Conoley and Conoley (1992) so aptly point out, "...promote behaviors best done by dead people" (p. 43). Expectations such as sitting still or remaining silent for extended periods of time may be developmentally inappropriate and applied only to maintain the comfort level of adults. The typical lifespan of such programs is approximately two weeks, if that. The child may be judged as noncompliant without consideration of the presence or absence of necessary skills for success or the possibility that the target behavior continues to be reinforced in other environments.

Finding Solutions

Perhaps the most positive environmental response to chronic behavior problems, with the greatest potential for accomplishment, emanates from the collaborative intervention model. Throughout the literature, collaboration has been explored as one means of improving the delivery of mental health services to children and their families (Conoley & Conoley, 1991; DeChillo, Koren, & Schultze, 1994; Epstein et al., 1994; Frieson, Griesbach, Jacobs, Katz-Leavy, & Olson; 1988). To insure its success, collaboration requires case management (Collins & Collins, 1994; Conoley & Conoley, 1991), team building (Gitlan, Lyons, & Kolodner, 1994), and the use of positive communication and problem-solving skills (Fine & Gardner, 1994). Furthermore, there are numerous theoretical constructs embraced by collaboration that may be helpful when fashioning intervention programs for children with chronic behavior problems. Three primary concepts are:

- Programming across environments (Conoley & Conoley, 1991; Evans and Okifuji, 1992).

- A focus on building strengths and remediating skills deficits (Collins & Collins, 1994; Conoley & Conoley, 1991), with an emphasis on progress rather than insistence on perfection.

- Structure with autonomy, allowing all team members (including family) equal opportunity to contribute to the problem-solving process, program implementation, and the evaluation process (DeChillo et al., 1994; Fine & Gardner, 1994).

Collaborative interventions have many advantages over the more traditional approaches to behavior management. The flexibility inherent in this type of model allows participants to hold membership in a variety of settings including home, school, support agencies, and the general community. With a shared vision and mutual support, multiple system interventions are likely to have a greater potential to positively impact target behaviors (Short & Shapiro, 1993; Webster-Stratton, 1993). This may be due, in part, to the fact that behavior is looked at in a larger context, addressing the full scope of the problem. A consistent message with regard to behavioral expectations can be communicated between people and across environments. This factor alone is likely to reduce confusion for the child, as structure and consequences are similarly applied at home and at school, as well as in the community (i.e., at scout meetings, Sunday school, soccer practice).

Another attractive feature stemming from the concept of flexibility is the ability of team members to cross territorial boundaries to work cooperatively in participating systems. For example, an agency counselor may be given the opportunity to visit a classroom and observe a child's interactions with peers. Information gathered from the observation paired with teacher consultation can serve to enhance therapeutic work outside of the school setting. With the agency counselor and teacher working in tandem, program effectiveness is likely to increase within as well as outside the school setting.

The shared responsibility recognized as an integral part of collaborative interventions (Fine & Gardner, 1994) is, in many respects, the cornerstone of program effectiveness. The ability to differentiate between roles allows for clarification and individualization of work tasks (Gitlin et al., 1994), while eliminating the confusion which may arise as a result of dual role responsibilities that often occur in single environment programs. The provision of mentoring becomes a real possibility when selected team members are allowed to step outside an authoritarian role to instead operate in a supportive role with identified children. For example, a person from the school staff who holds similar interests as the child (i.e., astronomy, computer technology, etc.) may take on the role of providing the child with special time and attention. Working together as a team also affords participants physical and emotional respite from direct care duties. This is especially important for parents and classroom teachers who spend the most time with the children. Rather than losing patience or hope as a result of isolation or lack of viable alternatives, primary caregivers are able to receive continuous support and assistance from others.

Perhaps, just as important to the collaborative intervention model as shared responsibility is the concept of empowerment. A consistently optimistic approach conveys respect and preserves the dignity of all participants, including the children, through belief in the ability of all to be positive contributors to the behavior change program (Dunst & Trivette, 1987). Empowerment rests on a foundation of unconditional positive regard, building self-esteem and self-efficacy. By its very nature, empowerment bypasses resistance as it does not seek to find fault or blame (McWhirter, 1991) instead building opportunities for autonomy and creativity into its structure. Rather than focusing on what is lacking, strengths are identified and used to teach new skills for success (Dunst & Trivette, 1987; McWhirter, 1991). Empowerment views behavioral change as a process, rather than event, and expects to support children through setbacks as well as successes.

The collaborative model has the capability of far exceeding traditional models in terms of outcome. Its focus, approach, and team-based techniques give rise to comprehensive intervention programs that effectively address chronic behavior problems by teaching children more effective behaviors and thereby improving their overall self- concept. New hope is instilled through "problem resolution" rather than "problem control" so typical with traditionally focused interventions. Collaboration provides a means by which we can positively impact the lives of behavior disordered children and their families as well as improve the quality of life for all residing in the community. The following case studies are offered as an illustration of the potential success that can be realized through the use of a collaborative approach.

Case Studies

Robbie

Robbie first came to the attention of school staff while attending kindergarten. Impulsivity, excessive resistance to classroom structure, and poor anger control were behaviors considered especially problematic. These behaviors continued over a period of five years and eventually served to cement Robbie's social isolation and feelings of persecution. All informal interventions attempted at school had failed to produce any long lasting changes in his negative behavior. When he was referred for evaluation in the middle of his fifth grade year, Robbie had no friends, consistently engaged in stealing at school, and was unable to complete academic assignments. Results of the psychoeducational assessment revealed a high rate of physical and verbal aggression, social isolation, noncompliance with adult requests and poor impulse and anger control. (In an attempt to remain sensitive to limited space, only the anger control portion of Robbie's intervention program will be described below.)

Given the persistence of his inappropriate displays of anger and the fact that previous single environment interventions had failed, it was decided that a collaborative intervention between home, school and a local support agency would be implemented. Robbie's parents sought family counseling and individual therapy for Robbie at the community mental health center. The counselor from the center was then invited to work directly with the school's Child Support Team in developing a suitable plan to help Robbie in gaining control of his anger. The team consisted of the school's principal, counselor, psychologist and Robbie's classroom teacher.

At school, Robbie attended biweekly counseling sessions with the school psychologist. During this time personal issues encountered in school were explored using a cognitive-behavioral approach. Robbie was also taught formal problem-solving skills to meet the challenges he encountered in the setting. Following mastery of major problem-solving concepts, the agency counselor was invited by the school psychologist and Robbie to participate in a joint brainstorming session to develop an anger management program. Efforts resulted in the following list of 14 alternatives that could be used to maintain control of anger at school:

Robbie's Meeting

Problem: How Robbie shows his anger at school.

Solutions:

1. Try not to be mad. Follow along with the class.
2. Write in my private journal.
3. Talk to an adult buddy.
4. Take a walk around the school.
5. Go to the office to cool off.
6. Buy 100 helium balloons and fly away.
7. Get a puzzle from teacher...and chill out!
8. Write down what I am mad about and put it in the counselor's "Worry-B-Gone" can.
9. Pick a student buddy to talk to.
10. Go to the gym or outside to shoot hoops.
11. Draw my feelings in the private journal.

12. Go help somebody and forget about being mad.
13. Talk to my pet rock.
14. Go to Pete's "Rent-A-Plane" and take off!

To formalize Robbie's plan, he would need support from school staff and thus he was asked to choose several key adults with whom he wished to work. The school psychologist volunteered to coordinate a meeting at which Robbie would have the opportunity to share his plan with these key adults. The agency counselor agreed to attend the meeting in a supportive role.

Before the meeting Robbie was given the responsibility of typing up his proposed plan and making copies for all those he had invited. He also worked closely with the school psychologist to develop an agenda for the meeting and to practice skills for facilitating the meeting. On the day of the meeting Robbie was rewarded by full attendance and active participation of all team members. A final program was negotiated with alternative strategies for anger management clearly spelled out.

Following the meeting, several team members expressed their appreciation at having the opportunity to interact with Robbie in such a positive way and felt the experience had helped to renew their commitment to support Robbie in achieving success. Implementation of the anger management program resulted in a reduction of inappropriate outbursts and aggressive behavior. Difficulties were still encountered however, on occasions when Robbie was not allowed to choose from his list of alternatives (i.e., substitute teacher was not made aware of the program) or when Robbie did not consistently attend therapy sessions at the community mental health center.

Frank

During his sixth grade year, Frank was referred by, what seemed like, the world. Although charming and polite at times, Frank frequently engaged in verbal and physical aggression at school. His large physical stature, combined with his persistence and tenacity, convinced most of his peers to let Frank have his way. Physical altercations with staff infrequently resulted in effective consequences due to the school's reluctance to involve his family. Although he was receiving special education services under the category of learning disabled, Frank was failing all subjects and spent most of his classroom time disrupting others. In the community Frank was faring no better, as he had acquired the supervision of the juvenile correction system after threatening a woman with a baseball bat. Despite all of the turmoil, outwardly Frank appeared quite comfortable.

An extensive evaluation found that Frank met the diagnostic criteria for conduct disorder while no evidence of a learning disability emerged. Given the latter finding, it was decided by the school's Child Study Team that he would be better served within the regular classroom using a collaborative intervention to gain control of his behavior and learn positive interpersonal skills. (Once again, in deference to space, only a portion of the following case will be described.) The creative use of community resources enlisted to implement the behavior program will be highlighted.

During a meeting of all interested parties, including Frank, a set of behavioral goals was agreed upon and an action plan developed. Within the school setting, three teachers, the principal, counselor intern and school counselor agreed to directly support Frank in his attempt to work toward goals. His classroom teacher agreed to work with Frank on the behavior program and allow him to earn points towards a special Saturday lunch treat. A second teacher agreed to provide him with a "cooling off" place in her classroom. This was a place Frank could go when either he or his regular classroom teacher felt he needed to gain better control of his behavior. In the "cooling off" room, he was provided with unconditional positive regard and a place to complete his assignments. The learning disabilities teacher assisted Frank in getting involved in a local theater group to which she belonged. This served to continue their positive connection and provide him with a positive outlet for his energy and the recognition he desired.

The school principal offered to include Frank in a group of boys who met with him weekly to build model airplanes. This gave Frank some positive time with a male role model. Given that the school counselor had agreed to take responsibility as case manager and monitor progress towards behavioral goals, she chose to refrain from acting as Frank's counselor to avoid dual role status. Instead, a counselor intern was enlisted as an impartial therapeutic ear for Frank.

Supportive adults outside of the school setting also provided Frank with opportunities to discover new interests and develop positive social skills. Through a regional university, he was enrolled in a bi-weekly after school sports program where he was able to interact with other boys his age who had similar interests. As a part of the services, on-site program counselors acted as mentors and coaches to the boys. Following the evening activities and before he was transported home, Frank had dinner with his group. Once at home, Frank's parents reviewed his progress towards behavioral goals and provided social and tangible reinforcement for such.

The intervention was successful in keeping Frank in school and helping him experience positive interactions with significant adults and peers. Initially Frank displayed a good deal of resistance, stating that he had no desire to be like other children. Improvement in behavior was realized after he experienced consistent application of the program across settings. Towards the end of the school year, he became less manipulative, engaged in more cooperative pro-social behaviors, and seemed genuinely pleased with his accomplishments at school and in the community. Frank and the world were beginning to make friends!

Summary

The case of Robbie demonstrates the unique aspect of actively involving the child in the development phase of an intervention. Giving him a sense of control increased his motivation to participate and work towards successful completion of goals. Involving significant adults across settings conveyed the message that Robbie was an important person who had the potential to grow. The intervention designed for Frank provided less autonomy, as it was necessary to increase structure to reduce potential harm to others. In addition to a strong message supporting change, the program's creative use of community resources allowed Frank to engage in new activities, opening the door to self discovery. With new experiences to guide him, he was able to begin the process of redefining himself and his relationships with others.

Rather than attempting to fit the children into already existing services, the case studies are positive demonstrations of the behavorial change that can occur when services are instead molded to the specific needs of children. In each case, families were actively involved. The question then arises: If collaborative interventions have a greater potential to bring about lasting change, why are they so seldom used?

When compared to traditional services, collaborative programs require a greater initial cost in terms of time and energy. Multiple schedules must be coordinated, differing philosophies must be blended (Cohen et al., 1992), and bureaucratic procedures must be altered to meet the challenges of funding and service delivery from a less traditional approach. A case manager must also be appointed to insure that the program runs smoothly.

As with any change, numerous barriers challenge the smooth transition from traditional to collaborative services (Melaville et al., 1993; Collins & Collins, 1994). However, given the high cost of minimal success typical of more traditional approaches, confronting and overcoming barriers appears to be a necessary course of action. If we are to improve mental health services for children and their families who struggle daily with issues resulting from chronic behavior problems, then we must be willing to craft a new vision for services offered in the community. Families, schools, social service agencies and community businesses must forge a new partnership, embracing flexibility and creativity to meet the individual needs of these children.

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> *“Competence, like truth, beauty and contact lenses, is in the eye of the beholder.”*
>
> –Laurence J. Peter, *The Peter Principle*

A Review of

Resilient Adults: Overcoming a Cruel Past

by Gina O'Connell Higgins, San Francisco, CA: Jossey-Bass, 1994
372 pages, ISBN 1-55542-673-5

Paula Helen Stanley

It seems that the counseling profession is becoming more and more focused on psychopathology and dysfunctional behavior, even though it professes its allegiance to a developmental model as the framework for understanding behavior and planning interventions. For example, the *Diagnostic and Statistical Manual, Fourth Edition (DSM-IV)* (1994) is commonly used by counselors and other helping professionals to understand client behavior. Individuals are classified and categorized and treatment plans developed based on these diagnoses. But these diagnoses are not enough. In focusing on the psychopathology, one may overlook the strengths and resilience of the client. These strengths and resilient qualities may play an important role in the counseling process.

Higgins, in her book, *Resilient Adults: Overcoming a Cruel Past*, articulates the importance of looking beyond the psychopathology presented by a client and exploring the person's strengths, abilities, and resilience. She proposes that more study is needed concerning the mechanisms by which some survivors of abuse have developed a resilience and ability to function in a more healthy way than those who are less resilient. Higgins estimates that 10% of those who were traumatized as young children and adolescents develop a resilience that results in better adult emotional health than expected. One definition of resilience offered by Demos (1989) is "the capacity to bounce back or recover from a disappointment, obstacle, or setback" (p. 3). It is a complex phenomenon that is sensitive to "contextual variables" (p. 4). Higgins provides numerous examples of how contextual variables have influenced the development of resilience in children.

Higgins' book is based on a qualitative study of 40 adults who reported significant challenging life experiences, such as sexual, physical, or emotional abuse, poverty, serious illness in themselves or others, and chronic family problems. In spite of these experiences, they developed a resilience, defined by Higgins as the ability to love well and to work well. She defined "love well" as the "ability to establish and maintain relationships marked by a high degree of reciprocity and concern for the other as well as the self" (pp. viii, xiv). To "work well" referred to job or career satisfaction.

Higgins interviewed the adults in her study to determine what factors influenced the development of their resilience. She presents case studies of the individuals she interviewed; telling their life stories, personal tragedies, and successes. The case studies are presented in a manner similar to those presented by Lifton (1993) in *The Protean Self: Human Resilience in an Age of Fragmentation*, in that the beginnings of resilient behavior in childhood were identified and presented as threads of influence that helped shape the resilient adult's sense of purpose and meaning in life. Many have invested themselves in helping others through social activism or careers in the helping professions.

Within each case study, Higgins discusses the crucial people and events which helped each individual continue to grow and develop, despite their hardships. What is revealed in these interviews is the importance of brief and even infrequent acts of caring. Teachers, extended family members, coaches, and school counselors provided enough emotional nurturance to foster the development of optimism and hope for the future. For Higgins' resilient adults, the school setting was particularly important. For some, school was the only place they felt safe or experienced a sense of order; it was a safe haven for many. One adult recalled that

> a ninth-grade high school English teacher, whom I respected a lot, asked us to do...an assignment where we had to write ten of our favorite poems...she wrote back to me "Thank you for sharing these. Now I have a much better idea of who you are and what's important to you," and I remember bursting into tears. It was a pretty middle-of-the-road comment, but yet...it just seemed so surprising that *anybody would know*....It was just that she "saw me" (pp. 156-157).

Resilient adults, as children, found a little caring and interest to be extremely powerful in the face of a barren and, for many, a harsh home environment.

Higgins also found that resilient children are more capable of recruiting "invested regard" from others than those less resilient. Kegan (1982) notes that

> ....some people have a much greater ability to recruit people's attention to them than other people do. This obvious fact, so underinvestigated by psychologists and so commonly denied by teachers—that the greatest inequalities in education were not between schools (of different economic strata, for example) but within them; that greater than the inequalities of social class or achievement test

> scores is the unequal capacity of students to interest others in them—a phenomenon not reducible to social class or intelligence, and which seems to be the more powerful determinant of future thriving (p 19.)

Some children need others to initiate an interest in them, as they have difficulty in recruiting it. In fact, some may at first refuse it.

Higgins concludes her book with two chapters which focus on the struggles of persons to overcome the effects of abuse and to live more satisfying lives. These chapters are written both for the survivor of abuse and helping professionals, including counselors, teachers, and psychologists. The recommendations given describe what helping professionals can do to better understand and to work with children and adults who have been traumatized by abuse.

Although Higgins' book is comprehensive in many ways, one limitation is the brief literature review concerning resiliency. More information on the prevalence and meaning of resiliency would be helpful to the reader. In addition, Higgins could have elaborated more on the struggles of her resilient adults between childhood and adulthood. She noted that some of the study participants would not have met the resilience criteria earlier in their adult lives, but did at the time of the study interview. The reader can only guess what transpired during the intervening years.

In summary, Higgins' book has much to offer counselors and educators. She reminds us that human beings are capable of great resilience and resourcefulness in the face of adversity. The resilient adults in her study had found a meaning and purpose in life that grew out of their unfortunate life experiences and the interaction with significant people who helped them develop a sense of hope and optimism about the future. It seems clear from her research that any act of caring, no matter how small, can have a significant impact on another's life. It may not seem that it matters at the time, but the long-term effects may be powerful.

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> “*The human understanding is like a false mirror, which, receiving rays irregularly, distorts and discolors the nature of things by mingling its own nature with it.*”
>
> –FRANCIS BACON, *NOVUM ORGANUM*

A Review of
Breaking the Cycle of Violence: Interventions for Bullying and Victimization

by Richard J. Hazler, Washington, D.C. Accelerated Development, 1996.
220 pages, ISBN 1-56032-508-9

Brent M. Snow

This is a book about bullying and victimization. Written by a counselor with a great deal of counseling, psychotherapeutic, and teaching experience, the book is an overview and discussion of young people in trouble. The author provides a model for therapy and direct actions applicable for individuals and groups. Prior to the first page, the forward to the book clearly communicates that this is not a typical text. The author introduces the topic in a personal, transparent, self—disclosing style that sets the tone for the remainder of the book. A story in the forward by a colleague of the author amplifies that personalized tone. One particular paragraph is descriptive:

> On that late-winter afternoon, however, in my old school for the first time in 19 years, I realized how close to me those problems had stayed. As I sat on that wooden bench in the gymnasium, with the camera in front of me, and that friendly producer standing nearby with a smile on her face, suddenly it all came back-that musty smell of sweat, the cold from sitting there in those thin blue shorts and the white T—shirt, that feeling of impending doom, that churning sick feeling, the fear of what would happen during and after gym class, in the locker room, in the shower, in the halls, in the lunchroom, on the playground, on the bus. . . .I guess there are some things you never forget. The things that happened to me have affected me all my life whether I was thinking about them or not. You try to put thoughts and feelings away in a forgotten place, but they come back at times and in ways you don't expect. I hope Richard's book will help adults understand and deal better with their problems and the problems of their children. Most of all, I hope it will lead to safer and more secure childhoods for young people, that lead them to better quality lives as adults.

The book consists of three sections, ten chapters, and 220 pages. The first chapter focuses on answering the "whats", "whens", and "hows" of being a bully, a victim, a bystander, and an overview and impact of the problem. Chapters two and three present excellent examples utilizing short case studies augmented by discussions of important implications and relevant research. Each of these latter chapters contains a figure (table) listing characteristics, associated issues, and related research notations that serve as concise, helpful summaries.

Chapters four, five, and six outline a three stage model for therapy with bullies and victims in conflict. The author presents the model (Promoting Issues in Common) in a clear, engaging manner including examples cited from case studies. Steps in each stage of the model are identified and provide enough structure for the reader to follow and incorporate without being overwhelmed by flow—charts and "directional arrows".

The last four chapters of the book give a valuable overview of specific and direct actions that individuals and groups can take. These chapters contain the translation of ideas in the previously presented model to application. The author rightfully cautions that these action oriented concepts and suggestions should not stand in isolation but should be incorporated within an organized system (such as the model presented in the book). Four groups are identified and suggestions for activities and actions are given for each. More specifically, ideas are given for schools and communities; classroom teachers; counselors, psychologists, and social workers; and bullies, victims, bystanders, and parents. Ideas for the last two, in particular, provide a wealth of suggestions for use in therapeutic situations and in counseling. For example, the author emphasizes the need to see the bully prior to the victim to protect the victim from being blamed for "telling" and becoming the recipient of additional bullying.

This is a very readable book that can be appropriately labeled as "reader/practitioner friendly." It would be difficult to imagine that this book would not be a valuable resource for any counselor working with youth. In particular, those who work with kids in the early adolescent years and in middle/junior high schools will find this text to be a real treasure. While the book has immediate application for school counselors, it has broad application across settings and counselor specializations.

Brent M. Snow is a professor and chair of the Department of Counseling and Educational Psychology at the State University of West Georgia. Correspondence regarding this review should be sent to Brent M. Snow, Ph.D., Department of Counseling and Educational Psychology at the State University of West Georgia, Carrollton, GA 30118.

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1. Manuscripts should not exceed 20 pages.

2. Manuscripts should be typewritten, double-spaced (including references and extensive quotations) on 8½" x 11" nontranslucent white bond with 1 1/2" margins on all sides.

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